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Chemist&Druggist
The Newsweekly for Pharmacy

C&D

10 July 2004

Pharmacists to get vote on new Charter

Lloyds puts consultation area ads on TV

Don't forget LIFT, warns UniChem

Digby Emson: patient choice in pharmacy

REFERENCES: 1 CDR Weekly 12th June 2003; 13 (24). www.hpa.org.uk/cdr/PDFfiles/2003/cdr2403.pdf. 2 Shanks GD, Gordon DM, Klotz FW et al. Clin Infect Dis 1998; 27 (3): 494-499. 3 Sukwa TY, Mulenga M, Chisdaka N et al. Am J Trop Med Hyg 1999, 60 (4): 521-525. 4 Lell B, Luckner D, Ndjave M et al. Lancet 1998; 351: 709-13 5 GlaxoSmithKline, Data on File (MAL005) 6 Summary of Product Characteristics for Malarone, July 2002. 7 Summary of Product Characteristics for Malarone Paediatric, Aug 2003. 8 GlaxoSmithKline, Data on File (MAL001).

Prescribing Information: Refer to SPC before prescribing. Malarone® Tablets ▼ (250mg atovaquone/100mg proguanil HCl) and Malarone® Paediatric Tablets ▼ (62.5mg atovaquone/ 25mg proguanil HCl). **Uses:** Malarone: Prophylaxis and treatment of acute, uncomplicated *P. falciparum* malaria, especially where pathogen may be resistant to other anti-malarials. Malarone Paediatric: (for those 11-40kg) Prophylaxis only. **Dosage:** Take once daily with food or milky drink. Repeat dose if vomit within 1 hour. Prophylaxis: Start 24-48 hours prior to exposure, continue during stay (max 28 days) and for 7 days after leaving. Adults and children >40kg: 1 Malarone (250/100mg) tablet daily; 31-40kg: 3 Paediatric tablets daily; 21-30kg: 2 Paediatric tablets daily; 11-20kg: 1 Paediatric tablet daily. Treatment: Take as a single dose for three consecutive days: Adults and children >40kg: 4 Malarone (250/100mg) tablets; 31-40kg: 3 Malarone (250/100mg) tablets 21-30kg: 2 Malarone (250/100mg) tablets; 11-20kg: 1 Malarone (250/100mg) tablet. **Contra-indications:** Hypersensitivity to any ingredient, creatinine clearance < 30mL/min if for prophylaxis. **Precautions:** Treatment: Consider alternative therapy in acute malaria presenting with diarrhoea or vomiting, creatinine clearance <30mL/min with acute *P. falciparum* malaria. Use additional agents to treat *P. vivax* or *P. ovale*. **Interactions:** Metoclopramide and tetracycline reduce atovaquone levels. Co-administration with rifampicin and rifabutin not recommended. Indinavir levels reduced. **Pregnancy & Lactation:** Balance risks against benefits. Not recommended in lactation. **Adverse reactions:** Headache, abdominal pain, diarrhoea, fever, nausea, vomiting, anorexia, coughing. Blood dyscrasias, GI disturbance, transient LFT increases, amylase increase, insomnia, dizziness, fever, angiooedema, hyponatraemia, stomatitis, rash, urticaria, pruritus, hair loss. **Legal category:** POM **Presentation and Basic NHS Cost:** 12 Malarone Tablets £22.92. 12 Malarone Paediatric Tablets £7.64 PL 10949/0258/0363 **Marketing Authorisation Holder:** Glaxo Wellcome UK Ltd trading as GlaxoSmithKline UK, Stockley Park West, Uxbridge, U811 18T. Further information is available from: Customer Contact Centre, GlaxoSmithKline, Stockley Park West, Uxbridge, Middlesex, U811 1BT, customercontactuk@gsk.com; Freephone 0808 100 9997.

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This week

Pharmacy

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Regulars

Features

Council revises Charter and agrees on ballot

by Gary Paragpuri
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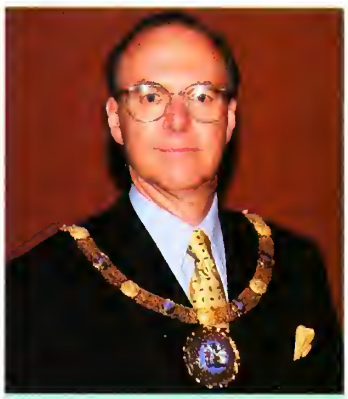
The Royal Pharmaceutical Society's Council has agreed on a revised Charter that gives greater prominence to its professional representative role. The Charter will now be put to a referendum of members this month before being sent to the Privy Council.

Council made significant changes to the Charter after taking further account of members' concerns, the Society said. These include:

- Replacing object three, which sought to promote the profession of pharmacy and support pharmacists' professional interests, with "to safeguard, maintain the honour and promote the interests of pharmacists in their exercise of the profession of pharmacy". This object has also been promoted to object two in the Charter.
- Replacing the former object two (now object three), which sought to promote and protect the public's health by regulating the profession, with "to promote and protect the health and wellbeing of the public through the regulation and professional leadership of the pharmacy profession and the regulation of other persons engaged in related activities".
- Requiring members' approval for: any new membership category; any proposal to change the Council's composition; and any changes to the Society's constitution.
- Acknowledging the potential for devolution in measures relating to any future winding up of the Society.

The revised Charter, together with explanatory material and voting form, will be sent to members this month. Ballot results will be presented to Council at its September meeting, allowing the Society to seek a new Charter in parallel with the Government's forthcoming legislation on the regulation of health professions, to be issued for consultation in the autumn.

All Council members approved the changes except Martin



Astbury and Bob Michell who were not present, and Sid Dajani. He abstained in part because the Charter's benevolent objective was reduced to being a power, but added that he would be campaigning for a 'yes' vote.

Welcoming the Council's decision, president Nick Wood said pharmacists could now have their say on a Charter that underpinned the Society's future as a professional development and leadership body. "It is absolutely crucial that membership now supports this way forward and, on behalf of the Society's Council, I urge all members to use their right to vote and say 'yes' to this revised draft," he said.

The SOS group, instrumental in bringing about the revisions to the Charter, said this latest draft version now ensured greater representation for pharmacists, protected the Society's assets and enhanced democratic control over future Councils. The SOS group also welcomed the Privy Council's request to appoint an additional pharmacist to Council, bringing the total to 18.

The restoration of the object to promote pharmacists' interests and its placing above the object concerned with regulation meant that the Society's representative role had been reaffirmed, the SOS said. Additionally, the fact that the regulatory object was now linked with professional leadership demonstrated Council's belief that there is a public interest element in having a well-led profession, it said.

However, SOS recognised it did not achieve the setting up of a distinct board to carry out the Society's regulatory role under delegated powers. "It became clear during the Council meeting that the Government was not prepared to negotiate on this point and would impose its view ... that there should be a single Council accountable for all of the Society's activities," the SOS said. But it added that the Charter allowed for the setting up of bodies to advise Council on professional leadership and development. "This paves the way for a strong focus to be placed on professional representation within the Society's activities."

Council members Graham Phillips and Noel Wicks also welcomed the revised Charter. M Phillips said it was important to ensure the RPSGB did not lose it representation role. "We can't allow it to drift back," he said, adding that members had regained the "democratic controls". He said the SOS's job had only just begun, and that it was not a single issue group.

Mr Wicks said: "An increased focus on the members must be reflected in all of the Society's activities."

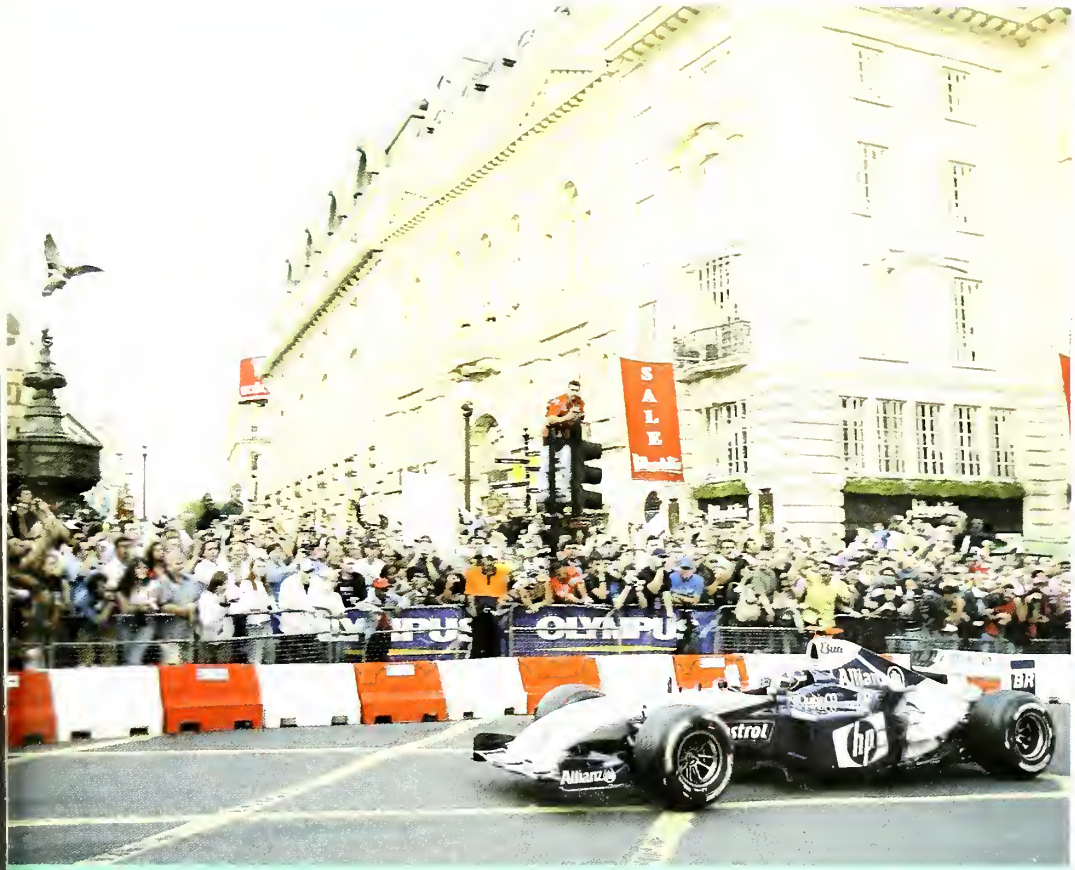
Mr Dajani added: "In the past, the Council was told that there were boundaries that could not be pushed but, at the outset, [England's chief pharmacist] Jim Smith said the Government was willing to be flexible. The Government has moved ground."

He added that the Charter is definitely stronger. "Members ea be asked to be balloted and, if articles have been broken, Counci members can be accountable."

Mr Dajani said Council would be reviewing all the decisions taken over the past two years to see if the yes or no decision should stand.

Dr Smith was unavailable for comment, but the DoH said once members had been balloted and the Society agreed on the Charte it will consider it in detail.

Council member Hassan Argomandkhah said although the SOS campaign had now been justified, SOS still needed funds to meet the cost of its campaign. Those who want to support it can contact him on 0151 4984840.



Lloydspharmacy advertises consultation areas on TV

by Asha Fowells
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Lloydspharmacy has launched a national television advertising campaign to increase public awareness of its private consultation areas.

The pharmacy chain has decided to promote the feature now that 1,182 of its 1,364 stores have designated consultation areas. The multiple had felt it inappropriate to raise customers' expectations during the roll out when only a small number of pharmacies offered the service.

Lloydspharmacy superintendent and pharmacy director Andy Murdock said: "People often feel uncomfortable discussing health matters in the general openness of the pharmacy. This is a clear demonstration of our commitment to championing people's health in the UK."

The consultation areas contain equipment for diagnostic testing and health promotion material. In addition Lloydspharmacy is considering installing IT connections. The advertising campaign, part of a £4 million marketing budget, started on July 5 and will run on terrestrial and satellite TV through the summer.

All stores with consultation areas offer blood pressure and diabetes testing. In addition, the areas facilitate the provision of local services such as emergency hormonal contraception, smoking cessation advice, coronary risk assessment, minor ailments schemes, medicines management and hosiery fitting and enable patients to discuss confidential health issues.

Although the majority of Moss Pharmacy stores contain private consultation areas, superintendent pharmacist Tricia Kennerley said the company had no plans to promote them via television advertising.

"We are still testing the water and have been piloting different concepts, including private areas and enclosed rooms, to see what works best for both patients and pharmacists. We are also conducting consumer research to see what they prefer," she said.

As well as trying to ascertain the criteria that consultation areas will need to meet under different levels of the new pharmacy contract, Ms Kennerley explained that other factors warranted consideration. "We are looking at opportunities in the new GMS contract such as out-of-hours services, for which consultation rooms will be needed."

The Royal Pharmaceutical Society's *Code of Ethics* provides guidance for pharmacies wishing to publicise the services they offer. A factsheet is available on the Society's website.

Five RPSGB posts

The Royal Pharmaceutical Society has announced five appointments as part of the roll out of its new staff structure.

Peter Wilson has been appointed head of post registration division from July 1. A former director of the Centre for Pharmacy Postgraduate Education, Dr Wilson will work on the development and implementation of strategies for CPD, revalidation, post registration training and specialisations.

David Gomez will be legal advisor from July 19; Liz Griffiths is head of the secretary and registrar's office; Janet Flint is head of support staff regulation; and Anne Adams is head of professional leadership.

NPfIT website

The National Programme for IT has launched a website – *www.npfit.nhs.uk* – featuring information about the initiative's various components including electronic care records, electronic appointment booking and the electronic transfer of prescriptions. Monthly reports received by the NPfIT board are also detailed on the site.

New RPSGB service

The RPSGB's publications division launched an online subscription service last Thursday.

MedicinesComplete.com gives access to publications including *Martindale*, the *BNF*, *Stockley's Drug Interactions* and *The Handbook of Pharmaceutical Excipients & Dietary Supplements*. The site also offers access to evaluated drug information and clinical data.

Driving guidelines

The British Medical Association is to draw up guidelines on driving under the influence of medicines. The project is likely to start later this year and will consider the effects of a person's illness as well as medication on driving. A spokeswoman said it was too soon to say whether pharmacy organisations would be consulted, as the project brief had not been finalised.

Public health online

The Scottish Specialists in Pharmaceutical Public Health Group has launched a website to support public health in Scotland, *www.show.scot.nhs.uk/ssipph*. It includes public health policy documents, a toolkit to aid pharmaceutical care needs assessment and details of pharmaceutical public health specialists.

AAH chief warns of rising medicine-related deaths

by Gary Paragpuri
gparagpuri@cmpinformation.com

Deaths caused by adverse drug reactions are set to double unless the public gains better awareness about medicines, Steve Dunn, AAH Pharmaceuticals group managing director, has warned.

The Government's programme to reclassify many medicines to make them accessible, without the need for a prescription, could lead to significantly more deaths than the current 10,000 per year, Mr Dunn said.

The problem is caused by a general lack of awareness about the potential dangers of drugs conflicting with other medication, said Mr Dunn, who is also British Association of Pharmaceutical Wholesalers chairman. But the situation could be improved through education from community pharmacists, GPs and the Government, he added.

"Pharmacists are the first and last line of defence in protecting the lives of thousands of people from potentially fatal adverse drug reactions. They are the gatekeepers between the public and their medicines," he said.

"Today, people have less familial support, more stress in their lives and more illness, which has increasingly caused them to turn to self-medication. At the same time they may never, or rarely, see a doctor. It is here that the pharmacist's role is vital. Through their professional knowledge and the delivery of medicines management programmes on the high street, they can help educate patients about medicines to help save lives and reduce the burden on the NHS."

Mr Dunn made his comments following a study in the *BMJ*, which found that ADRs cost the NHS £466 million each year.

Child chokes to death on Ovex tablet

Janssen-Cilag has warned that its over the counter worming tablet Ovex (mebendazole) should be crushed before being given to young children.

The company has expressed deep regret that a 33-month-old child from Liverpool died after choking on an Ovex tablet on February 29 this year.

The pharmacist who dispensed the product did not give evidence at Liverpool Coroner's Court, but provided the pharmacy's protocol for worming tablet sales and a copy of the patient information leaflet (PIL).

The company recommends pharmacists should advise parents to crush the tablet, especially if the child may have difficulty swallowing or chewing a tablet.

Janssen-Cilag says it intends to work with the Medicines and Healthcare products Regulatory Agency to revise dosage instructions in the PIL.

Coroner Andre Rebello recorded a verdict of accidental death on June 28.

Co-proxamol under review by MHRA

The Medicines and Healthcare products Regulatory Agency has asked for evidence on the risks and benefits of co-proxamol.

The request is part of an ongoing review being conducted by the Committee on Safety of Medicines because of a lack of evidence supporting its extensive use or clinical value. In addition, the review hopes to address the high number of overdoses associated with the drug.

The information required includes data from clinical trials, observational reports or other scientific studies; evidence of favourable risk to benefit ratios in specific patient groups; and evidence regarding the impact of locally restricting or withdrawing co-proxamol.

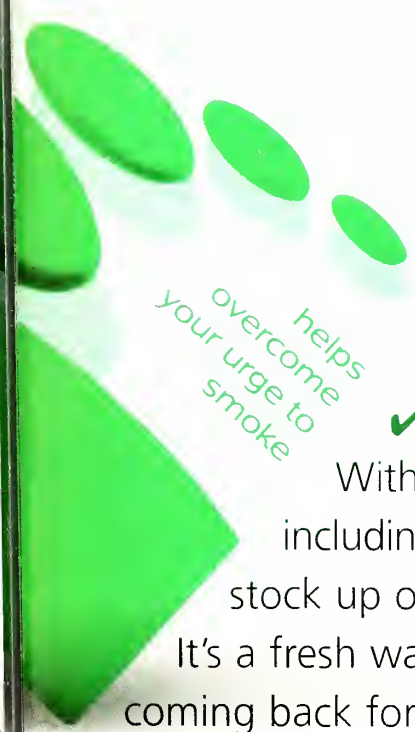
Possible outcomes of the review include restricting drug indications; strengthening information leaflet and packaging warnings; introducing smaller pack sizes; education to alter prescribing habits, and product withdrawal.

Further information is available on *www.mhra.gov.uk*. Responses should be addressed to Amanda Lawrence, MHRA Room 14-152, Market Towers, 1 Nine Elm Lane, London SW8 5NQ. The deadline for replies is September 22.

Bad news for cravings

new! Freshmint

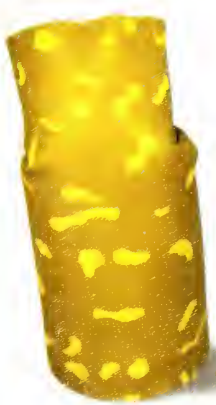
The best tasting gum ever from Nicorette is here.



helps overcome your urge to smoke

- ✔ New crispy coating
- ✔ Easy to chew
- ✔ Fresh minty taste

With a £6.5m promotional spend including TV, now's a good time to stock up on Nicorette Freshmint Gum. It's a fresh way to keep your customers coming back for more.



nicorette
nicotine

pfizer

The UK's best selling stop-smoking brand

SPGC supports proactive planning

by Adrienne de Mont
ademont@cmpinformation.com

The Scottish Pharmaceutical General Council supports proactive planning but does not agree with holding contracts to control pharmacy numbers.

Such contracts would undermine stability, remove confidence to invest and potentially hamper future service delivery, the SPGC says in its response to the Scottish Executive's consultation *Modernising NHS Community Pharmacy in Scotland*.

SPGC supported the proposal for NHS boards to keep a pharmaceutical care services plan (PCSP) stating where there is under or over-provision of services (*C&D, March 13, p4*). Pharmacies proposing services that matched local needs would be granted a contract but, if there was over-provision of services, a holding contract would be granted for a set period.

One category of under-provision would be an absence of one or more locally required services, but SPGC believes the regulations should be drafted to prevent cherry picking of services.

"Patients should have a right to expect a comprehensive pharmaceutical care service from all NHS pharmacies," it said.

Although the idea of contractors combining forces or moving to a new location is superficially attractive, says SPGC, careful thought will be needed on how to achieve it in practice. SPGC would need to discuss with the Executive what financial incentives might be used.

SPGC strongly believes that the contract should remain with the contractor. A named pharmacist should still carry responsibility for all service provision and that responsibility should extend to only one set of named premises at any one time.

Responses have been published on the Executive's website at: *www.scotland.gov.uk/library5/health/modnhsres-00.asp*

Two groups launch CHD screening

Numark and the West Midlands-based pharmacy chain Murrays Healthcare have launched coronary heart disease screening programmes.

The Numark package, produced in association with Health Diagnostics, contains protocols, staff training material and equipment including cholesterol and glucose testing kits and computer software to analyse patients' results. Numark is recommending that pharmacists charge patients £20 per check or use the kit to provide a PCT-funded service.

Numark professional services controller Mimi Lau explained that once the programme has been established, pharmacists could add osteoporosis screening and weight management services.

Murrays Healthcare is trialling different systems in two of its stores. A Wellpoint Interactive healthcentre has been installed at the Halesowen branch, whereas staff at the Old Hill store are required to perform tests manually. Patients are charged £2.50 for the service.

Superintendent pharmacist Dan Attry said the service will be audited and rolled out to more branches if found to be a valuable cost-effective service.

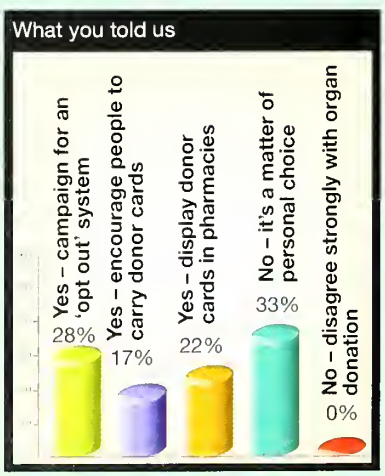
"We are looking at a number of initiatives ahead of the new contract that will impact on the public health programme," he added.

Questiontime

Last week we asked you: "Parliament has voted against an 'opt out' approach to organ donation. Should pharmacy take a stance?" You replied (see right):

This week's question: "In light of Lloydspharmacy's TV advertising campaign for its consultation areas, do you think the RPSGB should launch a national campaign to promote the profession on behalf of all its members"?

You can cast your vote on our website: *www.dotpharmacy.com*. You have until noon on July 14 to cast your vote. We will publish the results in *C&D*, July 17.



READY FOR THE SWITCH TO MAESTRO?

With less than 12 months to go before Switch disappears from the point of sale, the countdown is on for retailers to be ready for the move to Maestro.

Retailers responsible for 380,000 outlets are already signed up to the change, with the target set for the remaining Switch-accepting outlets to upgrade during the rest of 2004. Most Switch cards have already been co-branded, with the Maestro logo appearing alongside Switch on the front of the card. From July, Maestro-only cards start to appear and around 50% of cards will feature Maestro as the sole debit brand by the end of this year.

INTERNATIONAL CARD

The re-branding of Switch as Maestro will result in a truly international debit card. UK merchants will be able to accept foreign Maestro cards, and UK consumers will be able to use their cards abroad.

DISPLAY YOUR DECALS

Displaying the new Maestro logos will be crucial, according to Roger Alexander, Chief Executive of S2 Card Services Ltd - the independent company that administers the debit card scheme in the UK.

"Research shows consumers look for visual confirmation that the card they want to use is accepted. As people are currently less familiar with Maestro than they are with Switch, prominent display of Maestro logos will be particularly important," he advises.

ROGER ALEXANDER
Chief Executive, S2 Card Services

BIG BUSINESS

Debit cards are big business. Nearly two-thirds (64%) of all plastic card transactions are now by debit card and spending on Switch/Maestro in 2003 was a staggering £59 billion – up £6.3 billion on 2002. There were more than 1.5 billion Switch/Maestro transactions in 2003 – the highest ever since Switch was launched 16 years ago. This year is already seeing growth of 14% over the same period in 2003.

SUPPORT SPEND

To support the re-branding from Switch to Maestro, an £8 million campaign continues with TV and outdoor advertising, as well as a new website (www.switchmaestro.co.uk). Ongoing central advertising, marketing and PR support for Switch/Maestro will drive awareness, as will the banks' communications with their merchants and cardholders.

SWITCH Maestro

ALL CHANGE BUT NO CHANGE

- UK Maestro transactions will work in exactly the same way as Switch
- S2 Card Services is licensed by MasterCard to operate Maestro in the UK
- S2 is owned by the same UK banks that have always run Switch

HOW TO UPGRADE

- Outlets owning their POS terminals need to carry out a software upgrade but your bank will help you through the process
- Bank-owned terminals will be upgraded remotely by the bank, who will advise of the change.
- Where possible, upgrades will be made at the same time as those for Chip and PIN.

MAESTRO WILL COST THE SAME

- No changes are expected in the structure or level of domestic merchant fees as a result of the migration
- Fees will continue to be negotiated bi-laterally between merchant and bank, as before
- Domestic fees will remain as a flat rate – ie. pence per transaction.

MAESTRO OPENS INTERNATIONAL DOORS

- UK merchants will now have access to 530 million overseas cardholders
- 1 in 2 visitors to the UK from major tourist markets have a Maestro card
- UK cardholders can now access 10 million outlets and over 900,000 ATMs world-wide

KEY DATES

- Maestro-only debit cards have already started to appear and Switch will be completely removed from most cards by mid-2005
- New store stickers (decals) featuring the Maestro logo are now being issued by banks
- Solo debit cards are unaffected by the change

For more information visit
www.switchmaestro.co.uk

UniChem's LIFT warning

by Sasa Janković
sjankovic@cmpinformation.com

UniChem's non-executive chairman Mike Smith has again warned that the NHS's Local Improvement Finance Trust plan to revitalise primary care estate will have "serious implications for community pharmacy".

At a meeting of UniChem's Pharmacy Consultative Boards last week, Mr Smith reiterated that "this is new ground. Once the new contract hits, most pharmacists will be left standing."

The 42 areas in England designated for LIFT investment will see £1 billion made available for some 500 new one-stop primary care centres with or without pharmacies attached, and up to 3,000 GP premises refurbished or replaced.

With only two months to go until the first LIFT site comes on line at the Church Road Primary

Care Centre in East London, Mike Smith is urging pharmacists to continue approaching their PCTs about getting involved in LIFT in their areas.

He said: "UniChem's PCBs can talk pharmacists through the steps needed to take part in the LIFT process, but they must make every effort to speak to the LIFT lead in their local PCT.

"This can be very hard to do in some areas but pharmacists must be persistent, and then we can offer commercial advice. It is crucial that pharmacists get in on LIFT as fast as possible."

Chris Martin, a Pembrokeshire community pharmacist and chair of Pembrokeshire PCT as well as of UniChem's Mid West & Wales PCB, added: "If pharmacists miss their chance they can survive but will have to fight like hell to maintain the level of business they had. LIFT may be providing super-centres but communities still need servicing."

(*See p16 for more from the PCB meeting*).

For more information:
www.dh.gov.uk

ENGLAND

Ash steps up as new Lloyds md

Justin Ash has joined Lloydspharmacy as its new UK managing director, following the departure of Mike Ward at Christmas for Apax Partner's retail division.

Mr Ash was most recently managing director of KFC in the UK, Ireland and Iceland. He said: "Pharmacy is a growth sector and very exciting. It is going through a lot of change at the moment which I think to me will be for the good of pharmacy.

"My [illegible] working for companies that own their own assets and I think it is the people who are the most important part and make the difference."

ENGLAND

NHS and Inland Revenue tackle fraud together

The NHS and the Inland Revenue have signed a Memorandum of Understanding (MoU) aimed at cutting down fraud against the NHS. It will strengthen the flow of information between the two services, enabling the quicker prosecution of fraudsters.

It is hoped that it will be particularly effective in cases where patients claim to be unemployed to escape charges; staff members are claiming sick pay while undertaking other paid work illegally, and NHS staff are claiming for work they have not done.

Under the terms of the MoU, the Counter Fraud Services will be able to provide information to the Inland Revenue to help it pursue suspected tax fraud or significant tax evasion.

The NHS Counter Fraud and Security Management Service is holding the first ever conference on tackling fraud and corruption in EU healthcare from October 18-19. For more information visit *www.chfcc.com* from July 16.

ENGLAND

NHS Live in London marks year-long programme

Health Secretary John Reid and NHS chief executive Nigel Crisp launched NHS Live in London last week, along with patients and staff from 349 NHS and social care organisations.

The year-long national programme to pioneer new ways of redesigning health services for patients will begin to put the newly launched *NHS Improvement Plan* into practice (*C&D, July 3, p3*).

NHS Live is aimed at encouraging shared learning across the service including working with the private sector. Sponsors of the programme include Boots Plc, Oracle, AstraZeneca, Accenture, Fujitsu and Pfizer UK.

BR in Jordan

Leeds health supplement firm BR Pharmaceuticals has announced its first Middle East operation will open in Jordan this summer.

BR is teaming up with its existing distributor, Abu Sheikha, in Jordan, giving its sales and marketing team new footholds in Jordan, Lebanon and Syria.

Galen name change

Warner Chilcott would like to emphasise that although Galen Holdings has changed its name to Warner Chilcott, Galen Limited will continue to be known as 'Galen'.

AAH awards

AAH's Hospital Pharmacy Technician of the Year Supply Chain Award 2004 has gone to Judith Telford, dispensary and ward services manager at Hexham General Hospital, for her paper *The removal of Controlled Drugs from the hands of pharmacists*.

Nirmala Soma, community services co-ordinator, Glenfield Hospital, Leicester, won the Pharmacy Technician of the Year Clinical Award 2004 for her paper *Evaluation of a need for a pharmacy based interpreter/translator for non-English speaking patients of Asian ethnicity*.

Nucare range news

Nucare is launching three promotional magazines to strengthen its range of member services. Recent research revealed that not all members were fully aware of Nucare's range of stockholding of generics, PIs and OTCs, with the new magazines launched to meet this need.

COX to ALP

UniChem is updating its Mediphase ordering system and medical product directory to list Alpharma products under the category of 'ALP', replacing 'COX'.

UniChem has already changed invoicing descriptions to 'ALP' following Alpharma's name change from Cox in the UK in March 2001. The PIP/PROSPER codes will remain the same.

Boots in the zone

Boots is introducing dedicated Men's Zones into 80 of its bigger stores, according to *Marketing* magazine.

The Hackett men's grooming range, advertised by Jonny Wilkinson, will head up the initiative, with other brands stocked including Lambretta, Kangol and FCUK.

Animal test details remain secret

by Sasa Janković
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The Government has retained restrictions on the information about animal scientific procedures that can be accessed by animal extremist groups.

The restrictions in Section 24 of the *Animals (Scientific Procedures) Act 1986* forbid the disclosure of confidential information relating to the use of animals in procedures including medicines research. This prevents extremist groups gaining access to information that would help them target people in their own homes.

The Association of the British Pharmaceutical Industry has welcomed the news and supports Government's plans to publish anonymised information that will increase the data available on the nature and scale of animal testing.

"The UK-based pharmaceutical industry wants to be as open as possible on the role of animals in medicines research, but it is vital that such information does not help animal extremists perpetuate their campaign of fear and intimidation," said Dr Trevor Jones, director-general of the ABPI.

"We are pleased that the Government has decided to retain the 'confidentiality clause' of the Animals (Scientific Procedures) Act but we are also keen to explore options on how greater openness can be achieved without prejudicing the safety of the men and women who are striving to improve the health of the people of Britain."

The ABPI has published a booklet, *Animal Research and Human Medicine*, to tell children about the use of animals in medical research. It explains the importance of animal research in medicines development as well as the need to develop alternatives.

For more information:
www.abpi.org.uk

Numark adds another 75

Numark has signed up its 1,675th member only four months after reaching the 1,600 milestone.

Martin Gough, who has owned Ryder's Chemist in Formby for more than 10 years, is the latest pharmacist to sign up.

"The relationship I have built with my customers over the years is of paramount importance to me. I feel that Numark really does champion the needs of independent pharmacists, allowing me to retain my independence but benefit from a national identity," he said.

David Wood, chief executive of Numark, said: "We're delighted to have signed up our 1,675th member in such a short period of time and this is due to the great working relationships our business development managers have with their counterparts from Phoenix."

Martindale buys Eldon

UniChem has sold its Eldon Laboratories specials arm to Martindale Pharmaceuticals for an undisclosed sum.

Martindale, which has its own specials operation, says it "intends to continue the Eldon business as normal" under its ownership.

Maestro takes the stage from Switch

Retailers will see the first Maestro-only debit cards this month as the final stage of the re-branding of Switch to Maestro begins.

Most Switch debit cards have already been co-badged with the internationally recognised Maestro brand and replacement cards will no longer carry the Switch logo. For most cardholders Maestro-only cards will have been issued by mid-2005.

For both cardholders and merchants, Maestro cards in the UK will operate in exactly the same way as Switch has always done. The NPA says it will be alerting members to the change but does not foresee any problems arising from it.

Roger Alexander, chief executive of S2 Card Services, the management company for the Switch and Maestro brands in the UK, said: "Two thirds of all card payments in the UK are now by debit card and Switch/Maestro accounts for half of them."

Solo debit cards are unaffected by the change.

For more information:
www.switchmaestro.co.uk

Welsh pharmacists launch their four-year vision

by Adrienne de Mont
ademont@cmpinformation.com

Community Pharmacy Wales has produced a four-year vision statement setting out the main NHS services community pharmacies will deliver: minor ailments, medicines review, public health and dispensing.

The vision says everyone in Wales will be able to access a comprehensive minor ailments service and receive appropriate medication where necessary, in a pharmacy of their choice, without the need for an appointment and at a time to suit them.

Pharmacists will prescribe relevant medicines and agreed arrangements will allow GPs to refer to pharmacists, and pharmacists to refer to GPs.

Pharmacies will be contracted and recompensed by a fair return to provide a wide range of services for the prevention of ill health, including:

- promotion of mental health and emotional wellbeing
- enabling healthy choices in relation to obesity and smoking cessation
- reducing teenage pregnancy and improving sexual health
- reducing substance misuse and promoting sensible use of alcohol.

A key aim in CPW's four-year plan for 2004–08 is for well remunerated services, and CPW will work with PSNC to establish a robust, evidence-based cost analysis of services in Wales, to be updated regularly. Service templates will be maintained for each activity to ensure and demonstrate efficiency. A formula for funding new technology relevant to service developments in Wales will be agreed.

CPW will also develop closer links with contractors, who will be able to comment on how they would like to see services develop.

WALES

Needle exchange needs proof

A proposed needle exchange scheme in Wales may never happen unless the local health board can demonstrate evidence of a need for the service in the area.

Denbighshire Local Health Board has been asked by local councillors to produce evidence to support its request for Westminster Park Pharmacy in Rhyl to run a needle exchange scheme from its Vale Road branch (*C&D June 19, p5*).

Local residents and Rhyl South West councillor David Thomas have expressed concerns and questioned the need for such a scheme in the area.

Mr Thomas said the health authority should be looking at better facilities for substance misuse clients such as offering counselling and injection rooms on designated premises. The council has written to the LHB, which has acknowledged receipt of its invitation to provide evidence on need for the scheme and said it would reply in due course, he added.

Travel 'first' for Leicester school head

Professor Larry Goodyer, the head of Leicester School of Pharmacy at De Montfort University, has become the first pharmacist to be appointed to the British Travel Health Association's executive committee.

Prof Goodyer said he was interested to hear from other pharmacists who had an interest in travel medicine. He said they should consider joining the BTHA, as they would get access to bursaries for training in travel medicine and for project work.

For more information:
LGoodyer@dmu.ac.uk

PRACTICE

Guide must emphasise advisory role

The Royal Pharmaceutical Society has welcomed a patients' guide to complementary therapies but said it should put more emphasis on pharmacists' advisory role.

The Society commended the Prince of Wales's Foundation for Integrated Health on its *Complementary Healthcare: a guide for patients*, as being more authoritative than much of the information available to the public. But the Society added that the guide should emphasise the need for purchasers to ask for advice on products.

In response to the Foundation's consultation, the Society said the guide should point out the importance of discussing with pharmacists possible interactions between complementary and prescribed or other medicines, particularly as many patients do not recognise complementary therapies as medicines.

New role in Essex scheme

Essex pharmacists could have a role in a scheme to keep patients in primary rather than secondary care from early next year.

Community pharmacists could provide chronic disease management as part of the Tier 2 scheme. This is a phone-based, referral booking and management service designed to direct patients to the most appropriate specialist primary care service while reducing the number of hospital admissions. Essex Strategic Health Authority is keen to get pharmacists on board, said Priya Smith, manager of the Essex Community Pharmacy Practice Development Unit.

She expects pharmacists to be involved from about March 2005, when the scheme becomes involved in chronic disease management. It will focus on orthopaedics initially.

Some pharmacists are interested in asthma and COPD clinics, said Ms Smith. They will spend time with COPD nurses and learn spirometry techniques.

NHS IT gains patient input

The Government has launched a body to ensure that patients' views are fed into the National Programme for IT (NPfIT).

The Care Record Development Board, chaired by DoH director for patients and the public Harry Cayton, will provide clinical and patient input into the development of IT for the NHS. It replaces the NPfIT's patient and clinical advisory boards.

'Skills for the Future' hits the spot

The *Skills for the Future* programme, launched last month to help give pharmacists the competencies they will need to carry out medicines use reviews under the new contract, has hit the spot as far as *C&D* readers are concerned. Well over 600 pharmacists registered for the course within days.

Southport & Formby PCT is already offering to fund pharmacists who successfully complete the 'Skills' programme, as part of a pharmacy intervention scheme it plans to introduce in September.

The PCT's medicines management facilitator, Diane Sander, was planning to recruit local contractors to the scheme when the *Skills* programme was launched. She says the PCT scheme was planned with an eye to medicines use review, which is to be the main service within the advanced services tier of the new contract.

She quickly identified that the *Skills* programme could provide the ideal training element for the scheme, and was able to announce funding at the local community pharmacy development forum held last week.

PSNC chief executive Sue Sharpe has welcomed this commitment by a PCT to support community pharmacists in developing their services, and hopes other PCTs will follow.

Asif Khan, who owns pharmacies at Kexborough, Barugh Green and Silkstone near Barnsley, has registered himself and offered to pay for the programme for the three pharmacists he employs.

"With the new contract looming, we need to do something to ensure we are properly qualified. I am happy to provide these new professional services – as long as we are financially rewarded for our expertise – and do not want to be left behind," he said. "A course like this focuses the mind on what we should be doing."

Dr Dai John, a senior lecturer in clinical pharmacy, law, ethics and practice at the Welsh School of Pharmacy in Cardiff, was an early registrant. "I have enrolled for the course as I work in community pharmacy most Saturday mornings. The content and mode of delivery are cost-effective and convenient methods for me to maintain relevant CPD for these locum placements," he said.

PSNC's Yorkshire regional representative Dick Hazlehurst says the concept of *Skills for the Future* appealed to him, which was why he registered straight away.

"It deals with two year's CPD requirements in one fell swoop. It also gives independents an opportunity in CPD terms to work on the same level as large multiples, which can offer their own courses internally. This is a huge benefit."

However, he is concerned that he may forget to download the latest module from the *www.dotpharmacy.com* website. "It could be a problem for a number of users," he said, and suggested an e-mail alert for non-*C&D* subscribers who use the course (*see panel right*).

Sid Dajani, PSNC's NW Thames regional representative, found the programme inspiring and motivating. "If you are not riding the wave of change then you will find yourself beneath it," he warned.

"The *Skills* programme is the surfboard needed to stay afloat and keep abreast of change. In supporting your business, your professional interests and your patients I urge you not to bypass it."

For more information:
www.dotpharmacy.com
E-mail: *skills@medway.gre.ac.uk*
Tel: 01732 377269

Skills for the Future

Module 2 inside

- *Skills for the Future* is a PSNC endorsed distance learning programme administered by the Medway School of Pharmacy. It will enable pharmacists to gain accreditation to provide advanced services under the new community pharmacy contract for England and Wales. Module 2 is bound into this issue of *C&D*.
- Pharmacists can register for the course using the form on p21 of this issue. This is free of charge, but please ensure you complete all sections of the registration form correctly.
- A CD-Rom with assessment material will be delivered with Module 14 of the programme. You will not be asked to pay the assessment fee of £60 until you are ready to submit coursework to Medway School of Pharmacy for assessment.
- You do not need to be a *C&D* subscriber to register. Forms for registration can be downloaded from *www.dotpharmacy.com* – look under 'Education'. (To subscribe to *C&D*, call 01858 438809).
- All *Skills* modules can be downloaded from *www.dotpharmacy.com* until April 2005. An e-mail alert service to notify you when a new module is published is available. Module packs will continue to be available from *C&D* once the full programme has been published.

Skills for the Future is supported by an educational grant from GSK Plus.

Comment from the Editor

Vote 'yes'. That's the message from a united RPSGB Council. After a turbulent two years, the Society has finally come to an agreement on how the profession's new Royal Charter should be worded.

Both sides, the SOS group and the old guard 'modernisers', will be campaigning to get you, the pharmacists and proud members of the Society, to vote yes in the referendum on this new Charter.

The Society has yet to release the full version of Charter MkIII. But from the details that are available it is clear that one of the key Charter objects has been changed so that the Society will be able to promote the interests of pharmacists, something we were told was impossible last December.

Regulation has also been tied to professional leadership. And while the Government has apparently not given way on having the profession's regulation as the responsibility of the top-most Council, the new Charter will allow another Board to address professional representation and ultimately protect the members' assets.

One other thing – it seems that the Council will be more accountable to the membership; the need for which has become increasingly apparent after so many AGM motions have been ignored in the past few years, let alone the matter of last June's SGM.

But be warned – the delay in the Section 60 Order was more by luck than design, and if the profession doesn't approve this draft of the Charter, then it will be Government which decides the make up of Council, rather than the profession through its Charter.

To quote the Society from an earlier, happier time: "It's over to you."

It seems that the Council will be more accountable to the membership

Last week's question was: Parliament has voted against an 'opt out' approach to organ donation. Should pharmacy take a stance?

"I agree with organ donation and think pharmacy is a good platform to promote it"

Tricia Kennerley, Feltham

"We stock donor cards in our pharmacy and I would support an 'opt out' system"

Anon, Carshalton

"It is a matter of personal choice, but I would be happy to offer donor cards in my shop"

Jane Saunders, Carlisle

Yourviews

Roche could do better

I must disagree with *Xrayser's* assessment of the Roche Meter Update Scheme (*C&D, June 19, p15*). I assume that *Xrayser* is unaware that only a few pharmacies have been selected to participate.

For many years I sold Roche meters under its discount voucher scheme. The vouchers, together with the guarantee containing the patient's name and address, were returned to the company. Roche used these to build a mailing list of patients to whom I sold meters. Many of these patients have now received a mailshot advertising the meter update scheme, but directing them to alternative pharmacies.

I respect Roche's right to use such data to inform patients of their own products and services, but it is a gross breach of professional trust to use it to direct patients to visit other pharmacies (and offer them an inducement to do so).

Xrayser rightly says that diabetic patients are some of his most important. It now appears, thanks to Roche, that those of us who are not one of their preferred partners have sold our lists of these patients to our competitors for the paltry sums we were paid for selling Roche's meters.

Stephen Kane MRPharmS, Gravesend, Kent.

Recycle for charity

Many of your readers will have an old mobile phone or printer cartridge tucked away in a drawer at home or at work.

What they may not realise is that their unwanted items can benefit the Roy Castle Lung Cancer Foundation.

Old mobiles and empty printer cartridges can be recycled and the proceeds will be used to help fund research into the early detection, diagnosis and treatment of lung cancer as well as providing suppor for sufferers and their families.

Please help us continue our vital work with lung cancer sufferers and their families by donating old printer cartridges and mobile phones from home and work.

For details call 08712 50 50 50, or you can visit our website: *www.recyclingappeal.com/roycastle* or simply drop your unwanted items in the post to: Roy Castle Recycling Appeal (EL), 31-37 Etna Road, Falkirk FK2 9EG.

Janine Drew, fundraising manager, Roy Castle Lung Cancer Foundation, Liverpool.

Please e-mail your views to: chemdrug@cmpinformation.com

TOPICAL REFLECTIONS

Room for improvement

The NHS Improvement Plan seems to be a useful exercise in updating the objectives laid out in the *NHS Plan*. I expect it will revitalise the modernisation process and it is encouraging to see pharmacy get a few more mentions than in most previous Government documents.

The omission of one of the exemptions to the control of entry regulations and subsequent denial that this was significant suggests to me that the civil servants have not yet made up their mind on this one. I would love to know what new evidence or event they are waiting for to make up their mind.

Slightly worrying though was the continued commitment to transferring 50 per cent of prescriptions electronically by 2005. That is now only six months away and nobody seems to think the system will work from pharmacists' point of view. There are so many unanswered questions that I cannot believe it will happen. Am I going to need a new computer? Who will supply the software and train me and my staff? Who will pay for it? Can I be connected to N3 if I'm not in a broadband area? Do I have a choice as to whether I take part? These are just a few of the fundamental issues that must be dealt with.

While the looming new contract makes it difficult to make next year's business plan for several reasons, ETP alone throws up quite a few. There seems little point renewing the service contract with my current software supplier if I'll have to switch to another next year. I certainly won't buy any new hardware in case it's not compatible. And if I have to have a second computer, where on earth am I going to put it? I can only hope that ETP takes as long to implement as the new contract. Then I might have retired before it comes to fruition.

And so adieu, Voltarol Emulgel

It doesn't seem long since Voltarol Emulgel was granted a P licence and already the Novartis marketeers are pushing for GSL status. Nobody is likely to listen to my clinical arguments for retaining the P status of this product but manufacturers will surely take note if pharmacists stop recommending (or even stocking) their product. There are plenty of other equivalent (and cheaper) topical NSAIDs that I can recommend from now on, knowing that patients will have to return for their next purchase.

Small is beautiful

Perhaps one of the main problems for community pharmacists adapting to future practice will be a straightforward lack of space. Many premises will struggle to fit a consulting room, enlarged dispensary to cope with ever increasing script numbers, and whatever else is needed to deliver future services, inside their existing four walls. Space-saving ideas are welcomed and space hungry things are cussed in my pharmacy.

So the air turned blue when I saw the Bextra 40mg tablets pack. It contains just five tablets in a box big enough to hold at least 50. Products like this fill my shelves with fresh air at a time when I desperately need every cubic millimetre. I do not understand who the manufacturers (a joint effort between Pfizer and Pharmacia) are trying to impress with the packaging, but it certainly isn't pharmacists.

I recognise that the label has to be stuck on somewhere, and I can see the practicalities, from the manufacturers' point of view, of having all three strengths of one product (Bextra 10 and 20mg tablets are in packs of 30) in the same size packet. But it seems such a waste of cardboard when trees are in limited supply. Patients would benefit from packaging that looked distinctly different; I can't imagine doctors care one way or the other, and I'm sure it does the wholesalers no favours either.

So manufacturers, do pharmacists a favour: feel free to think big in all other aspects of your business, but when it comes to packaging please think as small as you can.

HOSPITAL REPORT

Power to the people?

How is this for the plot of a new soap opera? A large company is on the verge of a major deal with the UK government. A minority of the shareholders don't like the deal and manage to use the apathy of the majority to pack the company board with their candidates.

The chief executive is deposed and the despised deal put on hold. How will this affect the company's other government contracts?

A couple of possible storylines emerge. First, the new board reviews the deal, comes up with something more palatable to them and manages to sell it to the government and emerge triumphant at the next AGM. Second, the government, furious at the company for reneging on the deal, nationalises it under the High Powered Companies (HPC) Executive. Shareholders lose money and the credibility of the company sinks to an all-time low.

Sound familiar? The recent shenanigans at the RPSGB threaten to reduce pharmacy to a

The new Council must act quickly to restore confidence

laughing stock, remove any credibility that has been built up over the years and, most importantly, remove regulatory powers to the Health Professions Council. The concerns of the Privy Council members must have set alarm bells ringing throughout the profession and Government. The new Council must act quickly to restore confidence. Not least among those members who have seen their representation on Council cut to the bone.

Cynical hospital pharmacists are already concerned that the new Council is only promising to revive the interest groups (including the Hospital Pharmacists Group) to delegate any non-community pharmacist issues for them to deal with, rather than full Council. So much for representing the interests of all of the members.

Written by a senior hospital pharmacist

UniChem's five regional Pharmacy Consultative Boards met last week. [illegible] was there to hear them

Be prepared

The PCBs provide a forum for members to discuss pharmacy issues and feed back to UniChem on what practical help and advice independent pharmacists want.

Overall PCB chairman and non-executive chairman of the UniChem board Mike Smith said the meetings are useful as they provide pharmacist input at the highest level within UniChem, adding: "They are always lively and sometimes contentious."

There are many major issues in pharmacy at present but the lack of certainty over the contract is one of the bigger at the moment.

"The delay is of great concern but we offer support to customers by providing services such as our Portfolio service offering," said Mike Smith, "and this has evolved from PCB consultations."

Chris Martin, a Pembrokeshire community pharmacist and chairman of Pembrokeshire PCT as well as of UniChem's Mid West & Wales PCB, said: "The PCBs are successful because of the talent and experience of members and the commitment of UniChem itself. The PCB is the most exciting of my roles as we are helping to shape the future of UniChem."

Paul Benson, a Manchester community pharmacist and chair of the North West & Scotland PCB, agreed about the efficacy of the PCBs: "Grass roots pharmacists can mix with an array of talent and with UniChem directors and can learn a lot. This is not just a marketing tool for UniChem. Indeed, we make sure we give feedback to every single question from every member."

Mike Smith added: "UniChem's managing director David Coles has worked in many large organisations and has told us that the PCBs are the most sophisticated customer relationship tool he has ever seen."

From the left: Paul Benson, Mike Smith and Chris Martin

According to Mr Martin, UniChem's Portfolio scheme has been positively received by members. "Pharmacists think it is the sign of a forward-thinking company, as it allows smaller operations to be well prepared for the future just as much as larger ones such as Boots."

Mike Smith emphasised that pharmacists must be thinking about new services now and even start refitting. "They must prove to the PCTs that they are ready to go when it comes to delivering the services that the new contract will require," he said.

"It is inevitable that some will drive forward the profession and some will fall by the wayside," said Mr Martin.

> "The PCBs are successful because of the talent and experience of members"

Paul Benson agreed that "while we want to move forward, you can only do that with the pharmacies out there who want to move too," but he believes, however, that "there is more preparedness out there than you may think".

"The PCTs do see the new contract as an opportunity to drive pharmacy forward," said Chris Martin, "but pharmacy must be getting prepared for this now."

Mike Smith added: "I really believe that th pharmacies that the PCTs will go to are the ones that are proving they can provide the services. This may not be satisfactory but I think it is a fact."

Chris Martin agreed that this was harsh bu probably true, saying: "It's about local deliver It may seem that pharmacists are doing something for nothing now, but the PCTs wil then come to them once we know what's bein rolled out. There is not enough time for anything other than solutions at the moment. If pharmacists go to the PCTs with solutions they are on to a winner."

But of course, all this costs money. Mike Smith said: "I am concerned that pharmacy not at the top of the list in terms of funding from PCTs but it may have to take the initial hit to prove to PCTs that they should use it.

"However, any further delays in the new contract will damage the opportunity for it t work. If the Government loses the support pharmacy everyone will miss out."

Many people feel they haven't recovered from depression until they stop medication, but too rapid a withdrawal can lead to unpleasant symptoms, says *Mark Greener*

Stopping antidepressants

THE COLLEGE OF PHARMACY PRACTICE

This course (module 1308), in association with multiple choice questions being published in C&D August 7, provides one hour's continuing education

Learning objectives

- To appreciate the incidence of depression and its risks
- To be aware of discontinuation symptoms
- To be able to distinguish between these symptoms and other conditions
- To be aware of withdrawal regimens
- To know how pharmacists can help a patient withdrawing from antidepressants

Unless you have suffered from major depression, it is hard to appreciate fully the burden that it imposes. Apart from the low mood, even moderate depression saps your energy and leaves you lingering in a lacuna of self-neglect, malaise, fear and self-loathing. You're prone to a plethora of vague physical symptoms. Relationships at work and with partners and family suffer, sometimes irreparably. You lose interest in once much-loved hobbies and can't plan for the future. Depression's impact on your life is, in all but the mildest cases, pervasive and all-encompassing. Fortunately, pharmaceuticals, along with cognitive and other therapies, help resolve or alleviate symptoms in many patients.

Antidepressant treatment needs to last several months to reduce relapse risk. However, many people feel that they've recovered only when they stop taking antidepressants. Moreover, all current antidepressants are associated with several, sometimes unpleasant, adverse events. But stopping antidepressants doesn't just mean abrupt withdrawal, because this can provoke the distressing 'discontinuation syndrome'. This feature explores the symptoms, causes and management of antidepressant withdrawal symptoms.

A common condition

Depression is common. Between 5-15 per cent of the population experience at least one bout of major depression at some time during their life.[1] In a study from Bristol, 8 per cent of GP attendees were taking antidepressants.[2] Worldwide, depression accounts for around 11 per cent of the total years lived with a disability.[1]

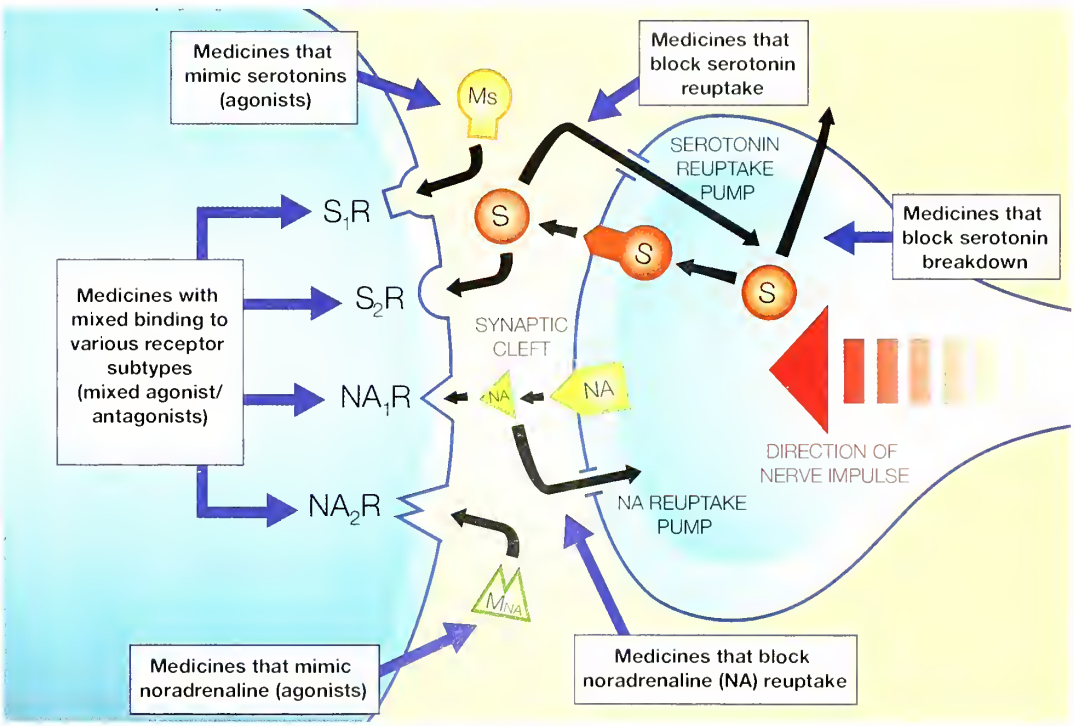
Depression also kills. Severely depressed, hospitalised people may be up to 30 times more likely to commit suicide than the general population. Even among people with milder depression, the risk of suicide may be 20 times higher than in the general population.[2] Depression also increases the risk of suffering from several potentially serious concurrent diseases, including alcoholism and drug addiction.

Against this background, monoamine oxidase inhibitors (MAOI) and tricyclic antidepressants (TCA), introduced in the late 1950s, saved countless lives and alleviated untold suffering. Over the intervening years, antidepressants gradually became more effective and better tolerated. As a rule, meta-analyses suggest that the SSRIs are as effective as, but better tolerated than, TCAs. A more recently launched antidepressant – venlafaxine, which inhibits the reuptake of serotonin and, at higher doses, noradrenaline – seems to be associated with better outcomes than SSRIs.[1]

Nevertheless, antidepressants are a long way from being panaceas. Depending on the drug and the patient group, 30-50 per cent of depressed people do not respond to antidepressants. Another 30-40 per cent show partial responses. Several factors seem linked to a lower likelihood of an adequate response, including: being female; being older; suffering from a physical disability or severe symptoms; hospitalisation and genotype.[1] For example, one recent paper found that a mutation producing an extra copy of the gene for

Continued on page 18 ▶

Modes of action of common antidepressive drugs on brain synapses



cytochrome P450 2D6 led to 'ultrarapid' metabolism of SSRIs. This mutation could account for one in 10 non-responders.[3]

New antidepressants affecting several novel targets and pathways are in development.[1] Moreover, a growing literature characterises the genomic factors that impact on outcomes. Indeed, the European Union recently donated €9 million to the GENDEP project, which aims to use genotyping to improve the diagnosis and treatment of depression.[4] Such advances should enhance antidepressants' efficacy and tolerability. However, researchers also need to overcome another pervasive problem: discontinuation symptoms.

Some of these symptoms, such as insomnia or depression, may lead the patient or physician to believe the depression has recurred, although this is unlikely if it seems the patient has responded fully to treatment. In other cases the symptoms are unrelated to depression, such as tingling or a flu-like feeling.

Depression is common and affects relationships at work and with partners and family, sometimes damaging them irreparably

Discontinuing TCAs

Stopping psychiatric and neurological drugs often leads to withdrawal symptoms. For example, the condition can re-emerge, often with renewed vigour. Epilepsy can rebound when benzodiazepines are withdrawn, for instance. Patients stopping hypnotics can experience worse sleep problems than before they started treatment.[2]

Pharmacists should remind patients stopping treatment or undergoing tapering protocols to watch for symptoms and consult their doctor immediately should these emerge. Pharmacists should also stress the importance of stopping therapy or reducing the dose only under medical supervision.

Discontinuation symptoms are distinct from the re-emergence of the disease. As drug levels in the plasma and brain decline, patients develop a variety of symptoms that are unrelated to the underlying disease. Again a wide variety of psychotropic drugs can cause discontinuation symptoms, including TCAs, MAOIs, SSRIs, neuroleptics and opiates.[2]

With some addictive drugs, the discontinuation syndrome can help to illustrate dependence. However, withdrawal reactions are only one aspect in a constellation of cognitive, psychological, emotional and neurochemical factors that comprise 'addiction' (see *C&D, December 20/27, 2003, p17-19*). Animals do not self-administer antidepressants, whereas rats, mice and other experimental animals do self-administer cocaine, opiates or benzodiazepines. Antidepressants don't produce a high and don't lead to cravings.[2] There is, therefore, little evidence that antidepressants are addictive in the same way as cocaine or nicotine.

Nevertheless, discontinuation symptoms can be relatively common among patients withdrawing from antidepressant treatment. For example, up to half the patients who abruptly stop taking TCAs, especially at doses equivalent to at least 150mg imipramine, develop withdrawal symptoms. (Severity correlates with the total daily dose.) Symptoms can emerge any time from a few hours – such as when patients miss a dose – to two weeks after discontinuing therapy.[5]

A flu-like syndrome is the most common discontinuation symptom. Patients report nausea, vomiting, gastrointestinal disturbances, malaise, cold sweats, chills, dizziness and headaches. Many patients also report insomnia and, sometimes, vivid frightening dreams. Mood disorders – including anxiety, panic attacks, mania and hypomania – can also emerge.[5]

Discontinuing SSRIs

SSRIs can also produce a discontinuation syndrome without causing rebound of the depression or anxiety. Indeed, even non-responders and healthy volunteers can develop discontinuation symptoms. Re-introducing the SRRI rapidly resolves the syndrome, whereas if symptoms were reflecting a re-emergence of the problem, patients would begin to respond only after several days (anxiety) or a couple of weeks (depression). So a re-emergence of the depression is not responsible for the symptoms, which tend to peak after between two and five days of drug withdrawal, and then subside over between four and 14 days. Occasionally symptoms last several weeks.[2,5]

Again, several of the symptoms that characterise the SSRI discontinuation syndrome are those the patient might not have experienced originally and can include: insomnia; dizziness; lethargy; headache; flu-like feelings reminiscent of the TCA syndrome; and paraesthesiae. Patients describe the latter as being similar to electric shock and the symptom can take three months to resolve. The patient may also experience dizziness, tremor, vivid dreams and sensory disturbances. Differentiating some discontinuation symptoms from 'true' flu can be difficult. However, patients who develop the discontinuation syndrome do not develop a fever.[2,5] If a patient on antidepressants requests a flu remedy, it might be prudent to ask if they have recently reduced the dose.

SSRIs with a short half-life, such as venlafaxine and paroxetine, seem to be especially prone to causing the discontinuation syndrome. The symptoms are less common with fluoxetine, which has a longer half-life.[2] Indeed, in one study no patient taking fluoxetine developed the discontinuation syndrome. This compares with 2 per cent and 14 per cent among those taking sertraline and fluvoxamine respectively. Paroxetine is most commonly linked to discontinuation symptoms – in one paper 20 per cent of users developed the syndrome.[5]

Possible causes

The cause of the SSRI discontinuation syndrome isn't clear. A rebound of cholinergic activity seems to underlie most discontinuation symptoms among people taking TCAs.[5] Chronic antagonism of a receptor or reduced transmitter levels seems to lead, in some cases, to an increased number of receptors. In other cases, the receptors become more sensitive. Both effects aim to overcome the blockade. So when the patient suddenly stops taking a TCA, the combination of higher acetylcholine levels and increased receptor mediated effects causes the withdrawal symptoms. As a result, the patient experiences more marked antimuscarinic side effects.

SSRIs are, however, only weakly anticholinergic. Instead, chronic SSRI treatment up-regulates the 5HT receptors that mediate reuptake. But reducing 5HT function in patients with depression who responded to SSRIs can trigger a relapse, without producing discontinuation symptoms. So serotonergic effects are not the sole factor underlying the syndrome.

Indeed, a growing body of evidence suggests that antidepressant withdrawal leads to a 'behavioural' stress response that increases the number of N-methyl-D-aspartate (NMDA) receptors in the hippocampus.[6] (NMDA receptors mediate the effects of the excitatory amino acid transmitter, glutamate.)

This finding fits in with other observations concerning depression's neurochemistry. People with depression show increased blood levels of glutamate. Moreover, the

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12 Hourly

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Morphine sulphate controlled release tablets

33% below NHS list price of leading brand[1]*

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- Comparable bioavailability to a leading brand of controlled-release morphine sulphate tablets at a b.d. dose[2]

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** 12 hourly controlled release morphine sulphate tablets*

obreviated prescribing information

efer to Summary of Product Characteristics before prescribing

orphgesic® SR 10mg, 30mg, 60mg & 100mg Tablets.

esentations: Controlled release tablets, each containing 10mg, 30mg, 60mg or 100mg Morphine sulphate. Tablet colours are mg – buff; 30mg – violet, 60mg – orange, 100mg – grey. **Indications:** For prolonged relief of severe pain. **Dosage and dministration:** Dosage dependent on pain severity and history of analgesic requirements. Administer tablets orally twice daily at hourly intervals. For severe pain, one or two 10mg tablets twice daily recommended starting dosage. With increasing pain verity, increase dosage to achieve desired relief. Dosage may be varied by choosing combinations of available strengths (10, 30, and 100mg). Recommended that a patient transferred from another oral morphine preparation, having similar bioavailability to al morphine liquid, should receive the same total dose in one 24-hour period, divided between morning and evening ministration. Dosage titration and clinical assessment may be appropriate. A patient who previously received parenteral orphine prior to being transferred to Morphgesic® SR tablets, may require a higher dose. Dosage adjustment will be necessary compensate for any reduction in analgesic effect associated with oral administration. Use with caution post-operatively pecially following abdominal surgery, gastric motility should have returned and be maintained. For relief of post-operative pain, s not advisable to administer Morphgesic® SR during the first 24 hours, and following this, the dosage should be at physician's scretion. Morphgesic® SR tablets are not recommended for paediatric use. **Contraindications:** Respiratory depression, paralytic us, delayed gastric emptying, obstructive airways disease, known morphine sensitivity or acute hepatic disease, hypersensitivity any of Morphgesic® SR tablet constituents, acute alcoholism, head injuries, conditions with raised intracranial pressure. Not to given during an attack of bronchial asthma or to patients with heart failure secondary to chronic lung disease. Not commended for pre-operative use or for the first 24 hours post-operatively. Not recommended during pregnancy and lactation. ntraindicated with concurrent administration of monoamine oxidase inhibitors (MAOIs) or within two weeks of their continuation. **Warnings etc:** Use with caution or in reduced doses in patients with hypothyroidism, adrenocortical fficiency, impaired kidney or liver function, prostatic hypertrophy or shock. Caution in patients with obstructive bowel disorders, asthenia gravis, convulsive disorders, hypotension with hypovolaemia, diseases of the biliary tract, pancreatitis and ammatory bowel disorders. Also use with caution in the elderly, and opioid dependent patients. Do not use where there is a possibility of paralytic ileus. Should paralytic ileus be suspected, treatment should be discontinued immediately. Patients who are to undergo cordotomy or other pain-relieving surgical procedures should not receive Morphgesic® SR tablets for 24 hours prior to surgery, if further treatment is then indicated, adjust dosage to the new post-operative requirement. Do not change to other controlled release morphine or other potent narcotic analgesic preparations without re-titration and clinical assessment. **Interactions:** MAOIs (see above). The depressant effects of morphine are enhanced by central nervous system depressants such as alcohol, anaesthetics, hypnotics and sedatives, tricyclic antidepressants and phenothiazines. The gastro-intestinal effects of morphine may affect activities of other drugs. Cimetidine inhibits the metabolism of morphine. Morphine potentiates the effects of tranquillisers, muscle relaxants and anti-hypertensives. Do not give mixed agonist/antagonist opioids to patients treated with morphine. **Adverse events:** Common side-effects of morphine at normal doses are nausea, vomiting, constipation, drowsiness and confusion. Micturition may be difficult and there may be ureteric or biliary spasm. There is also an antidiuretic effect. Dry mouth, sweating, facial flushing, vertigo, bradycardia, palpitations, orthostatic hypothermia, restlessness, changes of mood and miosis also occur. These effects occur more commonly in ambulant patients than in those at rest in bed. Raised intracranial pressure occurs in some patients. Larger doses of morphine produce respiratory depression and hypotension with circulatory failure and deepening coma. Death may occur from respiratory failure. Toxic doses vary considerably with the individual. Tolerance and dependence may occur. Paralytic ileus may be associated with opioid usage. Other effects include bronchospasm, headache, colic, rash, myoclonus, disorientation, hallucinations and decreased libido. Morphine has histamine-releasing effects which may be responsible in part for reactions such as urticaria and pruritus. **Legal category:** PDM. CD(Sch 2). **Marketing Authorisation numbers:** Morphgesic® SR 10, 30, 60 & 100mg Tablets PL 06464/1651-1654. **Marketing Authorisation holder:** Amdipharm, Regency House, Miles Gray Road, Basildon, Essex, SS14 3AF. **Basic NHS price:** 60 x 10mg tablets £4.09, 60 x 30mg tablets £9.81, 60 x 60mg tablets £19.15, 60 x 100mg tablets £30.30. **Date of preparation:** April 2003 (030317MG006). Further information is available from Amdipharm, Regency House, Miles Gray Road, Basildon, Essex SS14 3AF.

References: 1. MIMS, December 2003. **2.** Amdipharm, data on file (GAMPPK01)

Date of preparation: December 2003.

AMDIPHARM

031127M... 20

hippocampus seems to be smaller in people with depression compared with healthy controls (*see C&D, June 12, 2004, p21–23*). Hipppocampal size seems to be associated with the number of episodes of depression that the patient suffers over his or her life.[6] However, more research is needed to determine if such findings lead to methods for predicting which patients are likely to develop discontinuation symptoms, or novel therapies to attenuate the syndrome or improve depression management.

Disturbed sleep can be a sign of discontinuation symptoms

Further research

Further studies need to identify the optimal strategy to prevent and treat the discontinuation syndrome. Current approaches are based largely on 'commonsense and guesswork'.[5] For example, clinicians should gradually reduce the dose of antidepressant, rather than abruptly stopping treatment, over at least a week. Tapering should last longer if symptoms emerge. In some cases, reducing the dose by as little as 1mg a week might be appropriate.

Avoiding alcohol is prudent because of its depressant effects.

If patients cannot tolerate the syndrome, the dose should be increased until symptoms resolve and then tapered more slowly. If patients still develop symptoms, switching to the long-acting SSRI fluoxetine may help.[2,5] Switching to the liquid forms of the SSRI can allow the dose to be reduced more slowly than with solid dose formulations. This might be worth suggesting for especially difficult-to-treat cases. Pharmacists can also help by ensuring that GPs are aware of the therapeutic options for managing patients who want to discontinue therapy.

It is critical, therefore, for pharmacists to make sure that patients understand they must not suddenly stop taking antidepressants. Firstly, this increases the risk of discontinuation symptoms. Secondly, stopping treatment before the full benefits have emerged increases relapse risk. The risk of relapse is between two and four times higher among patients who cease therapy before full benefits occur, compared with those who continue.[6] Indeed, the relapse risk reaches 90 per cent among patients who experienced at least three bouts of major depression over the last decade.[2]

Pharmacists should, however, help patients keep the risks of discontinuation symptoms in perspective. There is little evidence that antidepressants are addictive. In contrast, up to 45 per cent of benzodiazepine users are unable to stop – one reason why SSRIs and venlafaxine are increasingly used to manage anxiety.[2]

Indeed, antidepressant withdrawal symptoms are usually relatively mild and almost all patients are able to stop.[2] Pharmacists can also reassure patients that although the discontinuation syndrome is unpleasant, the symptoms are not dangerous and abate over time.[5]

Depression is a debilitating condition, the impact of which often seems to be under-appreciated by people who haven't experienced it. Indeed, one recent paper comments that "depression is under-recognised, under-treated and, when treated, compliance is poor". The paper adds that: "Many depressed patients do not seek help."[1] Clearly, then, pharmacists should encourage people who are depressed (such as those enquiring about St John's wort or with signs of anhedonia [lack of pleasure] and self-neglect) to consult their GP.

Antidepressants can transform the lives of people with depression and those around them. But despite depression's pervasive impact, few people want to remain on antidepressants for life. Discontinuation symptoms can be disturbing, unpleasant and frightening. However, judicious prescribing and sympathetic counselling can reduce the risk that patients will develop this unpleasant syndrome.

References:
1. Moret, C. Current therapy and future treatment strategies for depression. J Psychopharmacol 2003; 17: 337–41.
2. Nutt, DJ. Death and dependence: current controversies over the selective serotonin reuptake inhibitors. J Psychopharmacol 2003; 17: 355–64.
3. Kawanishi, C, Lundgren S, Ågren, H et al. Increased incidence of CYP2D6 gene duplication in patients with persistent mood disorders: ultrarapid metabolism of antidepressants as a cause of non-response. Eur J Clin Pharmacol 2004; 59: 803–7.
4. Europe backs bid to tailor anti-depressants. Nature 2004; 428: 791.
5. Balon, R ed. Practical management of the side effects of psychotropic drugs. Marcel Dekker 1999; pp53–4, 104–6.
6. Harvey, BH, McEwen, BS and Stein, DJ. Neurobiology of antidepressant withdrawal: implications for the longitudinal outcome of depression. Biol Psychiatry 2003; 54: 1105–17.

Actionplan

1. In your practice workbook note each time an antidepressant is prescribed. At the end of each week (of, say, a four-week period) compare this with the total number of items dispensed. What is the ratio? Any thoughts? Discuss this with some of your local doctors, colleagues and friends. How does this reflect on life and our society?

2. Record any scripts that indicate stopping antidepressant therapy. Compare this with the number of prescriptions issued for these drugs (see the first point). How many indicate a tailing off regimen? Is it enough? What regimens are used? Do you get many scripts for the liquid form, which might indicate tailing off?

3. Have any patients reported to you discontinuation symptoms? How were they treated? Was the antidepressant re-introduced and then more gradually withdrawn?

4. What advice do you give patients who ask about starting a course of antidepressants? In the light of this article, will you now re-assess this advice?

5. Many patients ask about when to stop taking their prescribed antidepressant. What advice will you now give? Has it changed from before reading this article? Should you ensure the patient is aware of the possibility of discontinuation symptoms?

6. In your practice workbook list the commonly prescribed antidepressants. Record each script for them over, say, two weeks. Compare your result with colleagues outside your immediate area. Does the choice vary with the area? Does this have any significance?

Mark Greener, a former research pharmacologist, now works as a freelance medical writer and journalist. He is the author of numerous articles and several books on health-related issues.

Distance learning for pharmacists

Pharmacists using **Pharmacy Update** for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C&D's readers can self-test their progress by using the multiple choice questions (MCQ) paper to be inserted in the August 7 issue, which will cover this week's CPP-accredited module, together with those in the July 17 and 24 issues. These will cover:

- **Coming off SSRIs (1308)**
- **Ankylosing spondylitis (1309)**
- **SSRIs in cancer (1310).**

A telephone marking service offers independent verification of results – details on the monthly MCQ papers. People wishing to register for Pharmacy Update can contact Mary Prebble on 01732 377269.

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St John's wort effect on drugs shown

A review of trials investigating St John's wort has concluded the herb does decrease concentrations of conventional medicines when taken concomitantly.

Seventeen of the 22 trials reviewed demonstrated a decrease in systemic bioavailability of various conventional drugs when taken with St John's wort, an international team of researchers wrote in the *BMJ*. However, the researchers could not identify clinical thresholds over which the herb would significantly affect drug bioavailability.

Healthcare professionals and patients should be aware of possible interactions between St John's wort and conventional medicines and better information is needed for clinical practice, the authors conclude.

Of 1,360 patients taking warfarin, 19.2 per cent were also taking a complementary or homoeopathic medicine, a study in the *British Journal of General Practice* has found. Of the 19.2 per cent, 8.8 per cent of patients were taking one or more herbal remedy known to interact with warfarin. Of all the patients, only 7.8 per cent had discussed herbal medicines with their GP. The report did not look at whether the patients had discussed herbal medicines with the pharmacist.

For more information:

BMJ 2004; 329: 27-30

Viagra heads up the pack

Viagra (sildenafil) remains the drug of choice for erectile dysfunction, despite three newer drugs following it onto the marke

No compelling evidence exists to suggest the newer drugs such a tadalafil (Cialis) and vardenafil (Levitra) are more effective than sildenafil, the *Drug and Therapeutics Bulletin* has claimed.

How tadalafil and vardenafil compare with sildenafil is unknown, and published studies suggesting men prefer tadalafil to sildenafil are unconvincing, the *DTB* said.

For more information:

DTB 2004; 42: 49-52

DTB: little proof for new modafinil uses

Use of modafinil, the non-amphetamine wake promoter, may prevent the underlying cause of excessive sleepiness from being treated. There is also little proof for its newly approved uses, claims the *Drug and Therapeutics Bulletin*.

Extending the drug's use to include shift work sleep disorder and obstructive sleep apnoea could mean the underlying cause of excessive sleepiness is overlooked or not addressed, says the *DTB*. Evidence for modafinil's benefit for these patients is "limited or unconvincing".

The drug may also reduce the use of continuous positive airway (CPAP) therapy in patients with obstructive sleep apnoea, says DTB. Although modafinil is effective in patients with narcolepsy, no head to head studies of modafinil and dexamphetamine have been carried out, DTB says.

DTB acting editor Ike Iheanacho said: "The broader licensing of modafinil is of concern; there is little compelling evidence to justify this potentially indiscriminate use and the drug may increasingly be used as an unsatisfactory alternative to addressing whatever's causing the sleepiness."

Dr John Shneerson, Papworth Hospital's Respiratory Support and Sleep Centre director, said: "In addition to its first-line use in narcolepsy, modafinil has been shown to relieve persisting excessive sleepiness in obstructive sleep apnoea patients despite CPAP treatment. Long-term data appears to show no clinically relevant reduction in CPAP compliance amongst patients taking modafinil for this reason.

"Unfortunately, excessive sleepiness is frequently under-diagnosed in the UK and its impact is underestimated. It is always important to identify and treat any underlying cause."

For more information:

Drug and Therapeutics Bulletin 2004; 42: 52-6

Charity support for stroke repor

People who have had a stroke should be identified and treated sooner, says a national charity in response to updated clinical guidelines published this week.

The Stroke Association has supported guidelines for best practice on stroke care published by the Royal College of Physicians.

The RCP has recommended a more aggressive approach to stroke prevention through cholesterol-lowering and blood pressure control, as well as faster diagnosis and treatment of all strokes.

For more information:

www.rcplondon.ac.uk

Scriptlines

Co-Diovan

Novartis has launched Co-Diovan (valsartan/hydrochlorothiazide) tablets in 160/12.5mg and 160/25mg doses of the angiotensin II antagonist and thiazide diuretic respectively.

The recommended dose is one tablet per day. Concomitant use of potassium supplements, potassium-sparing diuretics, salt substitutes containing potassium or other drugs which could affect potassium levels such as heparin, must be used with caution and potassium levels should be monitored frequently. There is no data on concomitant use of valsartan and lithium, so monitoring of serum lithium concentrations is recommended.

Common side effects include urticaria and other rashes, appetite loss, mild nausea and vomiting, impotence and postural hypotension which can be aggravated by alcohol, anaesthetics or sedatives.

Price: 160/12.5mg, 306-8509, £21.66; 160/25mg, 306-8517, £21.66

Novartis

Tel: 01276 698370

ActiFormCool dressing

Activa Healthcare has launched ActiFormCool, a sheet hydrogel dressing for treating leg ulcers, which is available on the *Drug Tariff*. The dressing hydrates dry, necrotic or sloughy tissue to prepare the wound bed for healing. It hydrates hyperkeratotic skin. The dressing can absorb exudates from the wound when the top liner of the dressing is removed.

ActiFormCool is available in two sizes 10cm x 10cm in packs of five, and 10cm x 15cm in packs of three.

For more information:

See *Price List*

Activa Healthcare

Tel: 08450 606707

Licence change

Protopic (tacrolimus) ointment can now be prescribed by any GP with experience of treating atopic dermatitis. The licence change was granted after more safety data became available on Protopic's use.

For more information:

Fujisawa

Tel: 01784 227500

Anyway-up wound spray

M&A Pharmachem is distributing Stericlens, a new 'anyway-up' aerosol containing sterile saline solution.

Designed for cleansing wounds, Stericlens incorporates a new aerosol technology, which allows the can to be sprayed from any direction, including upside down. As well as reducing waste, the improved aerosol format also allows for targeted wound cleansing and irrigation and the reduced risk of contamination.

Two sizes are available, 100ml and 240ml, priced at £1.94 and £5.08.

For more information:
M&A Pharmachem
Tel: 01942 816184

Zanprol boost

GlaxoSmithKline Consumer Healthcare is supporting its omeprazole brand, Zanprol 10mg tablets, with £1 million worth of consumer marketing and educational support.

The package, which will run until November, includes national and consumer press, radio and direct mail and will focus on the 'weeks free from recurrent heartburn' message. There is also a supporting direct mail campaign.

For more information:
GSK Consumer Healthcare
Tel: 020 8047 5000

Sachet succour for kids

Orbis Consumer Health is launching a sachet format paediatric ibuprofen suspension.

Available from next month, Orbifen for Children sachets each contain 100mg/5ml ibuprofen and are licensed as GSL for use in children aged over six months for the relief of muscular pain, symptomatic relief of headache, sore throat, teething and dental pain, as well as feverishness and symptoms of colds and influenza.

Sugar and colour-free, the strawberry-flavoured suspension joins a range that comprises P-licensed 100ml and 500ml POM-licensed paediatric ibuprofen suspensions.

Price: £2.79, £5.09
Pack size: 10, 20 sachets
Pip code: refer to *July 3 Price List Supplement*
Orbis Consumer Products
Tel: 020 8902 3736

Fresh look

To support the launch of the new Lynx fragrance, Get Fresh, Lever Fabergé is running a £1.4 million marketing campaign over the next two months.

The posters, postcards and press adverts feature a snowscape scene which, on second glance, appears to look like something very different, the company says.

Price: £2.99
Pack size: Bodyspray:150ml; Showergel: 250ml
Lever Fabergé
Tel: 020 8439 6100

Stronger for men

Kimberly-Clark's Kleenex for Men range is to be repackaged and improved next month, supported by a £3m relaunch campaign.

The mansize tissues brand will now include stronger tissues. Promotion includes point of sale materials, a three-for-two offer, and between December and February, TV advertising.

For more information:
Kimberly-Clark
Tel: 01732 594000

Make my cuppa chlorine-free

Tapwater can now be transformed into a refreshing, chlorine-free drink, following the launch of water additive Vivatap.

Presented in tea-bag like sachets, Vivatap contains a blend of natural coral algae, chitosan, shell and antioxidants and will alter the taste and mineral balance, as well as neutralising the pH of tapwater in just five minutes, the manufacturer claims.

About £500,000 worth of consumer magazine public relations and advertising is scheduled to support the brand during the latter half of this year. Point of sale material is also available.

Price: £2.99
Pack size: 18 sachets
Pip code: 306-5844
Brunel Healthcare
Tel: 0117 959 7040

Frontshop

Steri-Strips offer time on beach

Adverts for Nexcare Steri-Strip skin closures will appear in the women's consumer press this month in a campaign designed to highlight their ease of use and availability.

The 'Four hours in casualty when you could have been on the beach' message will also be directed to pharmacies, via the pharmacy trade press.

As well as Steri-Strips, the Nexcare range includes: Active Strips low allergy plasters, Micropore tape and a ColdHot pack.

For more information:
3M
Tel: 07836 7337856

Care for children's pain

Thornton & Ross has added a paediatric ibuprofen suspension to its Care range, the first of three liquid analgesic launches planned for the Care range.

The aim is to position the product, Care Ibuprofen for Children Oral Suspension, as a value for money alternative to branded preparations; the recommended retail price is 23 per cent less than the equivalent for the branded market leader, Thornton & Ross claims.

To support the launch, Care is offering pharmacists variable introductory discounts.

Care Ibuprofen Suspension has a P licence and is suitable for children over the age of six months.

Price: £2.79
Pack size: 100ml
Pip code: 284-9693
Thornton & Ross
Tel: 01484 842217

Jelly good lip gloss

Super wet-look, high shine finish for lips is now on offer through Rimmel's new Jelly Gloss lip glosses. Coty UK says the new range of five colours and a neutral variant is also presented in a non-sticky, transparent gel base that retains lip moisture.

Three colours: Yummy (melon), Moreish (pink) and Gourmet (clear) are available for distribution through independent community pharmacy. Superdrug and Boots will stock all six.

Price: £3.49
Pack size: 10ml
Coty (UK) Ltd
Tel: 020 8971 1300

Promotion

Brand focus

HealthAid Menovital™ – Essential nutritional system

MenoVital™ from HealthAid boasts 16 essential ingredients including Soy Isoflavones, Flaxseed, Siberian Ginseng extract and Starflower to help your body through one of the most challenging stages of a woman's life, the menopause. **MenoVital™** can be taken to help prepare the body for the many changes that may occur. Free from all common allergens and suitable for vegans and vegetarians, **MenoVital** from HealthAid retails at £9.99 for 60 tablets. Call [illegible] 8426 3400 for purchase and stockist information or visit **www.healthaid.co.uk**.

HealthAid

TV next week

Anadin: All areas
Bisodol: Sat
Bodyform: C4, five, GMTV, Sat
Califig: C4, Sat
Gavilast: All areas except TT
Gaviscon: All areas except TT
Imodium Plus Caplets: All areas
Lamisil: All areas
Listerine: All areas except U, GMTV
Nicorette: All areas except U, GMTV
Pro Plus: GTV, B, G, Y, LWT, CAR, TT, C4, five, Sat
Senokot: All areas except GTV, A, M, TT
Simple Oil Control: five
Traveleeze Soft & Chewy Pastilles: GMTV
Veet Bladeless Razor: All areas
Veet Ready to Use Strips: All areas
Vagisil: All areas

PharmaSite for next week: Zanprol – window, **Zanprol –** in-store, **Canesten oral & cream duo –** dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, C5-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

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Watching the

Roger King tells Adrienne de Mont about a repeat dispensing system in which he generates FP10s in his pharmacy

Dorset pharmacist Roger King has devised a repeat prescribing system with advantages over the one used in the pilot pathfinder sites.

What's more, he's been using it for more than a decade so knows it works. The key difference between his and the pathfinder system is that he keeps a stock of FP10s in his pharmacy and generates repeat prescriptions when required. He has no need to store and retrieve 13 pieces of paper a year for every patient, while strict safeguards ensure he cannot be accused of writing fake prescriptions.

Mr King has probably been interested in pharmacy computers longer than any other independent pharmacist. He was investigating EPoS more than 20 years ago and in the early 1980s came close to establishing a computer link with what was then his local surgery.

Although this didn't come to fruition, he started looking in earnest at repeat prescribing in the early 1990s. His aim was to reduce the number of long-term prescriptions that were crippling his small business in Lytchett Matravers. Nearly a third of his prescriptions were for six months or more, but the local GPs were reluctant to cut the amounts prescribed because *it* would increase their workload and result in patients making unnecessary visits to the surgery.

When Mr King proposed a system with neither of these inconveniences, the doctors agreed to give it a try. Dorset Health Commission, which was looking at ways in which community pharmacists might help reduce the drugs bill, was keen to pursue the idea but worried about the legal and ethical implications.

Mr King's argument was that an FP10 is two forms in one – a prescription under the Medicines Act and an invoice for payment under the NHS Regulations. So if it were split into separate forms for each different purpose, it would still fulfil the legal requirements.

The Royal Pharmaceutical Society was concerned about the surgery potentially directing prescriptions to the pharmacy, but became totally supportive when Mr King pointed out that there was only one GP practice and one pharmacy in the village so most patients were already using both. The scheme also would be voluntary for patients.

Another reservation was the potential for fraud, but his system has safeguards in that patients sign for all the medicines they receive so he cannot claim for items not dispensed.

Eventually the scheme got underway with 30–40 patients. There are now 200 and could be more, but Mr King is reluctant to expand until he moves into new purpose-built premises this August. The surgery has 4,000 patients in all. Those using his repeat prescribing system are all on chronic medication, mostly for coronary heart disease, and some for asthma and other long-term conditions such as thyroid deficiency.

Dorset Health Commission funded the set-up costs, while Poole Primary Care Trust now pays him about the same monthly fee as the pharmacies in the pathfinder pilots. Hadley Healthcare Solutions funded new software when a millennium glitch forced Mr King to change computer suppliers. Hadley modified its Eclipse program to cope with recording and generating prescriptions in the pharmacy.

As far as Mr King is aware, only one other pharmacy in Dorset is using the same method and no other computer suppliers can offer anything similar – but they are no doubt working on it, he adds.

Another PCT, which he prefers not to name, has a large number of pharmacies using Eclipse, which will be modified accordingly so they can run a similar repeat dispensing

service. But Mr King understands it will be up to the pharmacists to fund it themselves.

So what impact has repeat prescribing had on his business?

"Obviously there were immediate significant financial benefits through moving from more than three months' supply of medicines to 28 days," he says.

His dispensary shelves are noticeably uncluttered as he has no need to stock vast quantities of medicines – his stockholding has reduced to about a week's supply.

Patients like the scheme because they can get repeats immediately, whereas previously they had to ask the surgery at least one day ahead. While not every patient on chronic medication has chosen to join the system, none has ever wanted to come off it once they started.

"Judging by the amounts dispensed, we also seem to have improved compliance, although this is probably anecdotal rather than backed by hard quantitative evidence," he says. The increase in dispensing fees is more than offset by the reduced wastage from not dispensing unwanted medicines, he believes, and three-month prescriptions would have triggered the expensive medicines threshold anyway.

His system could work for any pharmacy. Although ideally suited to a rural situation like his, the system would meet the needs of any pharmacy having close working relationships with a GP practice. Mr King's customer base is mostly retired people who live locally, so it might be more difficult in a high street business with a changing population and prescriptions coming from a large catchment area.

Knowing when patients are likely to need repeats helps him plan his time more effectively, although he doesn't dispense in advance of the requests because it would be a waste of effort if they didn't need all the repeatable items.

"The main difference between this system and the one in the pathfinder sites is that ours depends on computers in the pharmacy and surgery, whereas the pathfinder sites are totally GP-driven and paper-based. Scottish pilots have shown that repeat dispensing works far better if it is pharmacy-driven. If you rely on GPs it's an extra chore for them. There's also more incentive for pharmacists to reduce long-term prescriptions."

The GP still has ultimate control of the prescribing because he or she has to sign the repeat prescriptions dispensed.

In the near future, Mr King would like to run a pilot combining his repeat dispensing system with ETP. While he is pleased with the results of his 12-year project, it remains to be seen whether the Department of Health might consider a similar venture for all pharmacies. He has suggested it, but had a less than enthusiastic response.

How the system works – as devised by Roger King

The patient asks to join or is invited to go on the system.

After approval, the GP issues a standard computer-generated FP10 for a 28 day supply, over-stamped with the number of repeats to be dispensed. The A-side is printed as for any other FP10 and lists all medication authorised for repeats. Were it not for the over-stamp, the form would be available for pricing. The A-side (authorisation) is kept in the pharmacy for 12 months, then shredded.

The B-side is in its usual form, acting as a list of medication for the patient and/or a repeat request form. The patient can keep this form or choose to have it filed at the pharmacy for the same 12 months.

The pharmacist enters the details of the authorisation into the Repeats Book, which is a file parallel to the PMR and is designed to count down to zero as each instalment is dispensed.

The pharmacist obtains blank prescription forms from the surgery and signs for them, with both surgery and pharmacy noting the serial numbers. The forms are stored in a locked fixed box in the pharmacy.

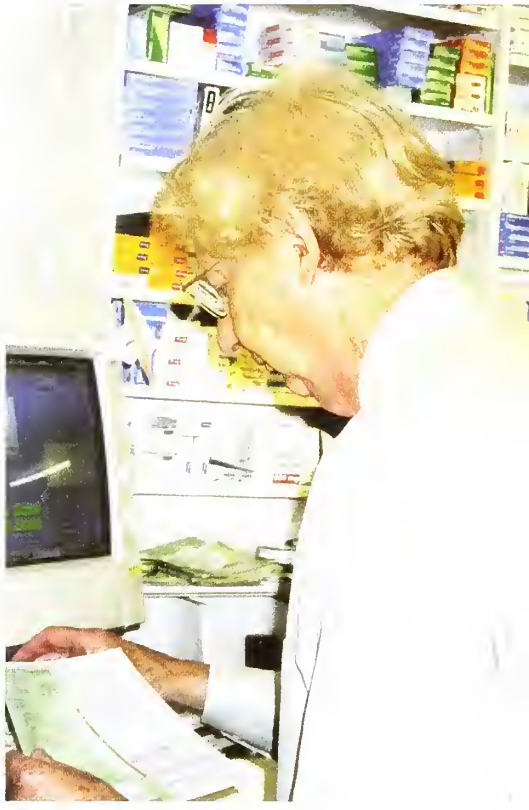
When a repeat is required, the pharmacist prints a standard FP10 on the blank form, dispenses the medicines and the patient signs for them.

The pathfinder pilots

- The GP issues a repeatable FP10, a master prescription that authorises a set number of repeats through 'batch issue' FP10s.
- The master prescription is kept in the pharmacy until a month after it is no longer required (that is after the last repeat has been dispensed, the prescription has expired or the medication is no longer needed), then sent for pricing.
- The batch issues are kept in the pharmacy or by the patient, who must return for dispensing to the pharmacy holding the repeatable FP10. The batch issue is not signed by the prescriber but must be signed on the back by the patient in the usual way. The space for the GP signature states which issue it is out of the total possible number of repeats.
- After dispensing, the pharmacist sends the batch issue for pricing. There are potentially 13 documents per patient to be stored in the pharmacy.

repeats

Repeat dispensing works far better if it is pharmacy-driven



The difference between surgery and pharmacy-generated FP10s is that the B-side of the latter lists only the items dispensed and appearing on the A-side. Hence, by signing the B-side, the patient acknowledges receipt of the items listed. The pharmacy-generated B-sides are filed in the pharmacy for 12 months for external audit.

The A-side prescriptions, which are already signed as usual by the patient, are taken to the surgery to be signed by the GP and submitted for pricing.

Before issuing repeat supplies, the pharmacist must ensure the patient is taking the medicines appropriately and not suffering any adverse effects. If the pharmacist has any concerns, the patient is referred to the GP.

The quantities of all medicines are synchronised. The pharmacist must not change the frequency, formulation, total strength, chemical entity or dosage. Patients seeking such changes are referred to the prescriber.

At the end of the repeat dispensing period – usually six months – the computer generates a history of all the medicines dispensed. This is taken to the surgery where it is checked against the patient's records. The GP can choose to see the patient or issue an authority for further supplies.

Spoilt for

The New Health Network, an independent multi-professional network that focuses exclusively on patient interests, organised a London conference last week looking at patient choice

Radical or sensible?

Digby Emson, Boots director of professional services, wrote the following article on patient choice in community pharmacy for a New Health Network booklet

Six million people visit a pharmacy every day. Boots sees 88 per cent of women and 70 per cent of men in the UK on average 30 times a year – one billion visits and 340 million opportunities to talk about their healthcare.

Impressive figures by any measure. By 2010, the implementation of the new pharmacy contract and the knock-on impact from the new general medical services contract will have become a reality. Add to that the impact from the implementation of the National Programme for IT with everyone having their own NHS care record and it is inevitable that community pharmacy will be playing an even greater role in helping people with their healthcare needs.

So what will it mean for the patient and the choices they will be making, the health service, and the health professionals delivering care?

Electronic transfer of prescriptions and the single electronic patient record will transform the way that prescriptions are handled and patient information is held. Technician checking and remote supervision will allow the pharmacist to spend more time with patients. Pharmacist prescribing, medicines management and more effective over the counter medicines will allow greater patient access to medicines and enable more clinical roles for the pharmacist to be realised. Quality, access and choice will have become the key drivers of community pharmacy care.

Technological advances will enable more point-of-care testing. Pharmacies will be screening the population for disease and will be monitoring patients' progress during treatment. Simple DNA tests will allow pharmacists to use pharmacogenomics to choose and tailor patients' medication for them. Live video and information links, unlocked by individual patient-held smart cards, via 24-hour pharmacies in every major town or city, will give patients access to information and pharmacist consultation at a time convenient to them.

It is inevitab that commu pharma will be playing even gr role, be Digby E left

IT would also provide individual access to wider NHS information and services such as online GP or hospital appointment booking. Pharmacists will help to educate people about the medicines they are taking and how to look after their own health, especially as more potent drugs become more widely available, translating and interpreting the plethora of information available to everyone from many sources. So what does this mean for patient choice? Quite simply, more. More choice about how they use NHS services; more choice about how they deal with common minor complaints; more choice about how they look after their own health.

Patients on long-term medication won't have to go to their GP surgery for repeat prescriptions; they'll be able to pick up their medication, have their condition monitored and their medication adjusted at a pharmacy of their choice at a time that's convenient for them. People with 'minor' complaints will go first to the pharmacy, where assessment will be made, with referral to their GP if the need is identified. Alternatively, they'll be treated in the pharmacy.

Minor complaints won't be limited to coughs and colds either; many common infections, including some sexually transmitted diseases, and self-limiting

choice

conditions will be dealt with through the pharmacy. Achieving the goal of a population fully engaged with looking after its own health, (*The Wanless Report 2004*), will result in health promotion campaigns that encourage people to check their health regularly and take action to reduce risks.

Where will they do this? In the pharmacy. People will be able to seek lifestyle advice, access health checks, medicines and other products that help reduce their risk factors, enabling them to maintain good health or manage their condition better.

How will it work for the patient? Let's look at one of the major public health concerns – heart disease – and examine how this will be tackled. Jointly funded health promotion campaigns will encourage people to go to their pharmacy to have risks assessed and to take action to reduce them. CHD risk assessment will include both cholesterol and blood pressure measurement.

If risk is low, lifestyle advice will be given on diet, exercise and other factors. The patient may choose to start taking supplements or make dietary choices that further reduce their risk. Those people in a medium risk category may be initiated on to medication, depending on whether they choose to take action, receiving a statin or antihypertensive. Regular visits to the pharmacy will ensure conditions are monitored and progress is tracked.

High risk patients will be rapidly referred to the GP for full diagnosis resulting in a health management plan and return to the pharmacy. The pharmacist will perform a DNA test and then prescribe the most appropriate medication based on the pharmacogenomic profile. From that point, the pharmacist will monitor the patient and handle all repeat prescriptions in close liaison with the GP with the reassurance that a seamless and accessible patient record is maintained.

All professionals involved in individual care plans will know what the patient is being treated for, what medication they are taking and what progress is being made.

Working in partnership with PCTs, pharmacies will develop services that meet local needs, locally contracted and paid for, no doubt audited against measurable outcomes. However, a small minority of people may choose to pay for the service and the medication that they receive, especially if a course of action isn't available on the NHS.

Heart disease is only one example of how patients will have more choice and better access and treatment options from their local pharmacy. It could just as easily be other individual or combinations of chronic long-term conditions like asthma or diabetes. Whatever the issue, patients will benefit from better, more appropriate and individually tailored care, responding to their needs.

We are at the dawn of a new beginning in pharmaceutical care and public health. Community pharmacy is rising to the challenge, offering unparalleled access and choice for patients. With the backing of the Government and NHS, it has the ability to increase capacity and help improve health outcomes significantly by 2010. NHS Walk In Centres? In 2010 that's what pharmacies will be. Is that a radical agenda or just plain common sense?

The New Health Network

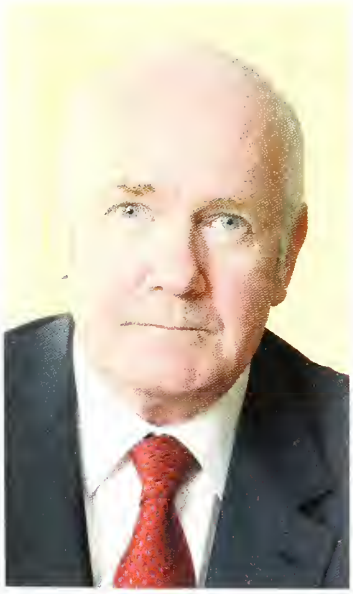
The New Health Network was established in 1999 by health professionals to promote positive change in the NHS. It is now a broad coalition of individuals and organisations strongly committed to sustainable health service modernisation.

The New Health Network works to help shape a future where the NHS fulfils its potential for all patients. Its aims include:

- policy and practice driven by patient needs
- good practice shared and built upon
- all NHS change benefiting patients and the public health
- staff, patients and the public actively involved in improving health policy
- society celebrating NHS success.

The New Health Network is a not-for-profit organisation committed to a safe, successful, efficient, caring health service funded through general taxation, available to all according to need, not ability to pay.

The organisation and its activities are funded through corporate subscriptions and income generation. For more information go to *www.newhealthnetwork.co.uk*



John Reid: a uniform approach to health service provision will fail to provide equity of provision

People power

Health secretary John Reid stressed that patient choice is a central plank of Labour's NHS reform plans, reports Gary Paraguni

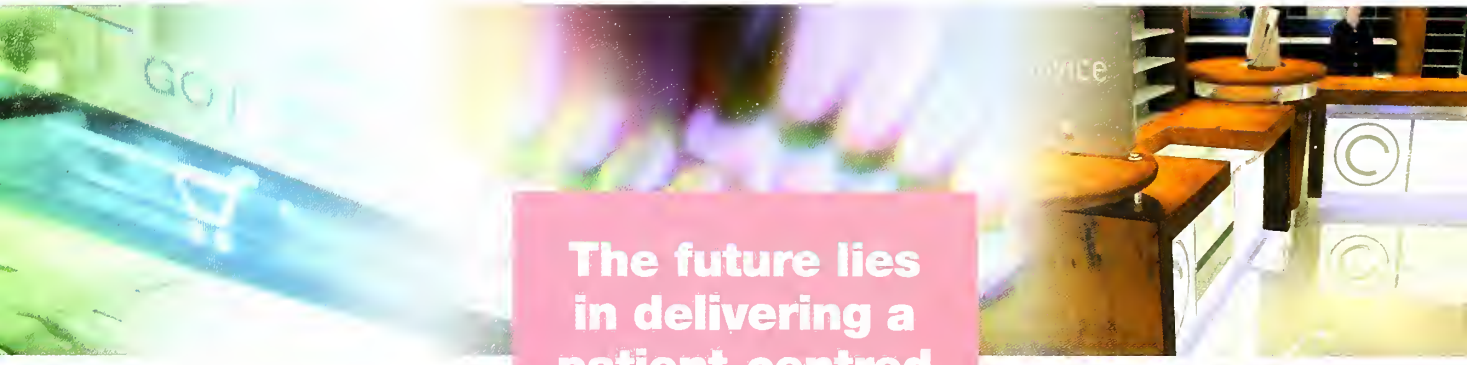
If you try telling health professionals that empowering patients through information and choice will improve standards and deliver greater health benefits, their response is likely to be predictable: they are already struggling to cope with huge rises in workload, and patient empowerment is unlikely to make this easier.

But according to the Government, increasing patient empowerment and choice is the very thing that will increase capacity within the NHS, as it will reform work practices and improve standards.

If you consider that different people have different needs, then a uniform approach to health service provision will fail to provide equity of provision for those people, argues health secretary John Reid.

Although diversity of provision will encourage equity, it will not, however, improve health if people cannot also choose

Continued on page 30



the health provision they wish to use.

So if patient choice is the way forward, how should it be delivered? Mr Reid outlines three political methods for delivering it.

Those on the right of the political spectrum believe the free market is the only clear way to deliver services, and that this market will only work if people are prepared to put their own money in. But this creates inequalities, he argues, which in turn reduces efficiency.

The centre says consumerism is king and this should be reflected in public services. This view is closer to the ideal but it has merit only if there is no cash transaction, says Mr Reid.

The left argument is that choice is already present in the system but is only open to those who can afford to go through the private sector. But jumping the queue limits the choices of the majority and extends preference to those who can afford to pay. Only one set of material conditions – the right to choose a health provider at the point of referral and not to be restricted by money – will allow patient choice for all without having to pay, and the health secretary argues that this is the way forward.

Further, this empowerment of patients, through the provision of information and choice, will drive improvements in health services if they are to meet patients' needs.

But this degree of choice will not be delivered by wishful thinking, he says. It is dependent on factors such as increased capacity, a wider range of services for patients to choose from, lower waiting times and lists, faster access to services and better use of IT – all of which Labour has been delivering incrementally, Mr Reid says and, with further developments announced in the *NHS Improvement Plan*, it seems Labour really is determined to turn theoretical choice into real choice.

The future lies in delivering a patient-centred service

Harry Cayton, DoH director for patients and the public

It may appear that secondary care is the focus of the Government's reforms but pharmacy should not think it has been forgotten. After all, control of entry, the new pharmacy contract, the reimbursement of generics, and the upskilling of pharmacy support staff are still awaiting ministerial decisions.

Choice alone not enough

Patient choice is only feasible if it is accompanied by information that is relevant to the patient's specific diagnosis or procedure, Roger Taylor, research director at information analysts Dr Foster, believes.

Patients need to be educated about choice,

Patients need to be educated about choice

Roger Taylor, research director, Dr Foster information analysts

and personal communication from health professionals is the hidden challenge of delivering patient choice, he says.

Dr Foster is currently working with the DoH and local NHS organisations to identify the best ways to target at-risk populations with effective communications. One method has been to copy the marketing techniques of major retailers and try to apply them to health. A pilot in Slough, Berkshire, aims to develop a communications toolkit that can reduce the cost of managing diabetes. About 7 per cent of Slough's population are estimated to suffer from diabetes, and just under half of them are undiagnosed. The sooner they are picked up the bigger the health improvement.

The trial selected four of the key population clusters most at risk of diabetes and then applied marketing techniques to find out which newspapers the four groups read, in which shops they bought their groceries and how they learned about new products. The results indicate that the four groups tend to use discount retailers rather than the market leaders and that they are more receptive to cold calling than using advice lines such as NHS Direct.

Choice is just a mechanism

The preamble to the *NHS Plan* is quite clear: the future lies in delivering a patient-centred service and nothing since has superseded this view, says Harry Cayton, director for patients and the public at the DoH.

Everything else, including patient choice, is a mechanism for delivering this, he says. Last month's *NHS Improvement Plan* continues this process by proposing shorter waiting times, extending choice, personalised care, self-management, electronic care records, chronic disease management and public health policies – all drivers towards a patient-centred service.

But before the goal is reached, the following will need to be addressed: a lack of privacy and time for consultations; a resistance to giving up control by healthcare professionals; training of staff in communication skills; a failure to feed back the lessons learnt; and ensuring equity by involving deprived and marginalised groups.

However, patients also have a role to play to help health professionals deliver a patient-centred service. Patient power demands a degree of self-management. Patients must learn to make decisions, utilise resources, develop effective partnerships with health professionals and take action – all examples of skills taught in the Expert Patient Programme.

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Clockwise from top left are Adrian Wilkinson, Cheryl Hall, Malcolm Hardy and Isabel Nisbet

Adrian Wilkinson has been promoted to the position of West Midlands Co-op's pharmacy division deputy general manager. Mr Wilkinson joined the company as business development manager in 2002, having spent nine years working as a community pharmacist.

Malcolm Hardy has been appointed regional sales manager for Nucare, with responsibility for the Midlands in England. Mr Hardy joins the company from the wholesaler Mawdsleys, and has previously worked for Laboratoires Garnier.

Alltracel Pharmaceuticals has announced the promotion of **Tony Richardson** from chief financial officer to chief executive officer. Mr Richardson joined the company when it was founded in 1996. Succeeding him as CFO is **John Kelly**, who joined Alltracel in April as alliances and acquisitions head. Founder and current CEO Gerard Brandon will remain at the company as a non-executive director.

The Organisation for Professionals in Regulatory Affairs (TOPRA) has elected **Cheryl Hall** as its president for 2004–05. Ms Hall has over 20 years' experience in the pharmaceutical industry and is currently senior director of regulatory affairs Europe for Johnson & Johnson.MSD.

Isabel Nisbet has been appointed interim chief executive officer for the Postgraduate Medical Education and Training Board (PMETB) until a permanent CEO is found. Ms Nisbet is currently carrying out project work for the Healthcare Commission and the Scottish Executive Health Department, and has previously been acting chief executive of the Council for the Regulation of Healthcare Professionals.

NDCHealth has appointed **Fiona Williams** as information services manager. She will be responsible for analysing the information held within the company's prescription data warehouse with a view to supplying information summaries to pharmaceutical companies. Ms Williams has previously worked for Enigma Health and Moss Pharmacy.

Pharmacist aims for peak performance

Pharmacist Fiona Urwin will be finding out that it isn't just pharmacy that's full of highs and lows when she competes in the annual Scottish Hill Rally for the first time this weekend.

Along with team mate and daughter Claire, Mrs Urwin is attempting to complete around 100 miles of competitive driving as well as 100 miles of road stages for the event that takes place in Perthshire. Only half of the teams that enter actually complete the event. Mrs Urwin commented: "We would very much like to finish, and finish without too much damage to the car, but we're very nervous."

Although Mrs Urwin has been involved in the sport for many years as a navigator, the pair only started driving competitively two years ago and are one of the few all-female teams on the circuit.

Mrs Urwin said: "We haven't got one of the fastest motors, but in the Northern Off Road Club Championship last year we were delighted to come seventh out of 80 teams overall."

No matter how bad the damage to the vehicle or the bruising she gets, it'll be back to work as normal on Monday for Mrs Urwin, who locums mainly for Moss in and around her home town of Washington, Tyne & Wear.

[illegible] Urwin in their clean and undamaged 4x4 rally car, prior [illegible] event

Mukesh Shah, Dilip Maroo and Ketan Shah prepare lunch for the walkers

Walkers raise over £17,000

Around 135 people took part in a 10km sponsored walk organised by The Oshwal Pharmacists (TOP) last month.

The walkers raised £17,760 for the NSS Polio Hospital in India, Macmillan Cancer Relief and the National Asthma Campaign. The cost of organising the June 27 event that took place in Potters Bar, Hertfordshire, was covered by Sigma Pharmaceuticals.

After the event, walkers were treated to a lunch of pizza and garlic bread cooked by TOP chairman Mukesh Shah, TOP secretary Dilip Maroo and Ketan Shah, husband of pharmacist Leena Shah, on special charcoal pizza ovens. The barbecue and refreshments en route were provided by Greens Pharmacy of Palmers Green in London.

Second success for golf champion

Yogesh Morjaria of Potters Bar, Hertfordshire recorded his second win in 10 years at the UniChem golf week recently.

Mr Morjaria was one of 60 pharmacists competing in the event that was held at Vilamoura in Portugal from May 8–15. His prizes included the UniChem Shield trophy, gift vouchers and entry to the UniChem Golfer of the Year event, which will be held at Hawkestone Park Country Club, Shropshire in August.

At the end of the second round, Mr Morjaria was in seventh place but an excellent final round resulted in him beating runner-up Sunil Patel of Wembley, London by just three points.

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The winners of this month's great Pharmacy Travel prize will receive £250 towards a city break and there are dozens of great locations to choose from!

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ate summer and early autumn is the perfect time for short break to Europe's fine historical cities. There e no large congresses or trade fairs so hotel prices duce and you can easily get into museums, galleries, id restaurants and see all the major sights without ieuing.

The huge increase in European flights in recent ars has opened up many exciting new and unusual ort break destinations. While you may prefer ditional 'grand cities' such as Paris, Rome, Vienna d Stockholm (known as the Venice of the North) ere are now some other great possibilities. How about fascinating Eastern European locations such as Budapest, Prague (above), Warsaw and St Petersburg or beautiful Spanish cities steeped in culture – Seville, Granada, Toledo and Cordoba.

If you enjoy spectacular lake and mountain settings you should consider Montreux or Lausanne (both nestling between the Swiss and French Alps on Lake Geneva), the ancient city of Verona near Lake Garda or stunning Salzburg in Austria. What a choice!

The prize is £250 towards the cost of any citybreak (for a minimum two persons travelling together) selected from the Cresta Cities brochure. It can be taken any time between 01 September 2004 and 31 March 2005 (subject to availability). No cash alternative is available.

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Coenzyme Q10 is a vitamin-like substance important for maintaining a healthy heart.

People taking statins to lower cholesterol may further benefit from a good dietary intake of coenzyme Q10 by taking a suitable supplement.

For more information call FREEPHONE 0800 591 756

Pharma Nord

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